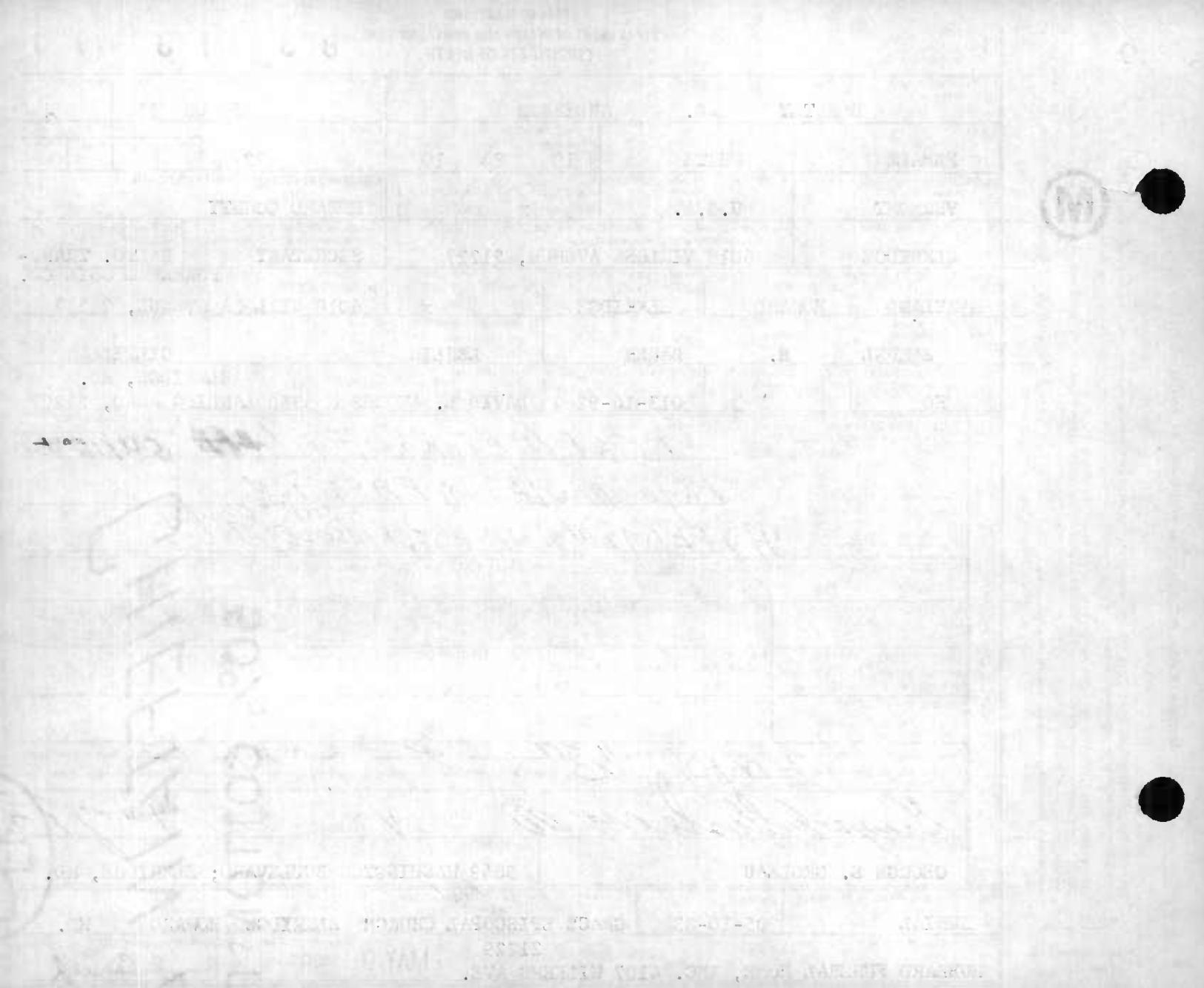


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8 3 1 3 5 9 0							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR			
DOROTHY B. ANDERSON												05	08	83		A M			
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH MONTH 10			DAY 24			YEAR 10	6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) VERMONT			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY			MD.				
10. CITY OR TOWN OF DEATH ELKRIDGE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6010 VIRLONA AVENUE, 21227			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY			12b. KIND OF BUSINESS OR INDUSTRY BALTO. TRANS-FORMER & COIL CO.										
13a. STATE MARYLAND		13b. COUNTY HOWARD		13c. CITY OR TOWN ELKRIDGE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 6010 VIRLONA AVENUE, 21227										
14. FATHER'S NAME FIRST SAMUEL			MIDDLE H.			LAST BAKER			15. MOTHER'S MAIDEN NAME FIRST LESLIE			MIDDLE GILFILLAN			LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 013-14-9244			17. INFORMANT DAVID L. ANDERSON			ADDRESS 5350 LANDING ROAD, 21227			ELKRIDGE, MD.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 HOURS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100			RESPPIRATORY FAILURE			DUE TO, OR AS A CONSEQUENCE OF (b) CYANOSIS IN FLAMMATION			HEART DISEASE										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE						
22a. I certify that (I) (this hospital) attended the deceased from 4-31-83 , 19 83 , to 5-1-83 , 19 83 , that (I) (we) last saw the deceased alive on 4-30-83 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.																			
22b. SIGNATURE <i>George E. Groleau</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5 May 83										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE E. GROLEAU			22e. ADDRESS 5849 WASHINGTON BOULEVARD; ELKRIDGE, MD.																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 05-10-83			23c. NAME OF CEMETERY OR CREMATORIAL GRACE EPISCOPAL CHURCH			23d. LOCATION CITY OR TOWN ELKRIDGE			COUNTY	STATE						
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.			ADDRESS 4107 WILKENS AVE.			25a. DATE REC'D. BY REGISTRAR 21229			25b. REGISTRAR'S SIGNATURE Jeanne Carney										
						MAY 9 1983													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it may be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 3 1 3 5 9 1	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
CHARLES					BITTERLI	5-10-83						10 ⁴⁵ PM	
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Male			Caucasian		MONTH DAY YEAR			92 YRS			MONTHS	DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8.			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS		
Swiss			USA		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Howard			MONTHS	HOURS	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Columbia			LORIEN Nursing Home			Chef, Retired			21044				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
Md			Howard		Columbia			YES <input type="checkbox"/> NO <input type="checkbox"/>			100005 Evergreen Ave, Columbia		
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST				
Late, Unknown					Late, Unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No						Charles Bitterli Jr, 100005 Evergreen Ave							
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			10 day										
Pneumonia													
4029													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost													
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure			yrs										
DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive cardiovascular disease			yrs										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
									YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 5/10 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.						19 00 to 5 10 19 82							
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN			MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED		
Charles E Taylor			(M)								5-10-83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			5999 Heron Run Rd. Columbia MD 21044							
Charles E Taylor (M)													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN				
Burial			May 13, 1983			Good Shepherd			Ellicott City Howard Md				
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Harry H Witzke, 4112 Columbia Rd Ellicott City						Md MAY 11 1983			John J. Conigli				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be informed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8313592
										REG. NO.
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
William Henry BURNER					05 27 83					M
3. SEX		4. RACE		5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)					
M		W		Month Day Year Feb. 24, 1907	76					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Virginia		USA				Howard				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NAME, ADDRESS, CITY, STATE, ZIP CODE)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY		
Jessup		8687 Pine Tree Road		plumber				U.S.Govt		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		
Md		Howard		Jessup				8687 Pine Tree Road		
14. FATHER'S NAME FIRST		MIDDLE		20794	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
Henry		W.		Burner	Nettie		M.		Rittenour	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS				
no		213 01 7725A		Robert L. Burner		8689 Pine Tree Rd, Jessup				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>4149</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Coronary Artery disease</u> DUE TO, OR AS A CONSEQUENCE OF years										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>SIMULT.</u>
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Chronic Obstructive Pulmonary Disease</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (the hospital) attended the deceased from <u>May 24 1983</u> , to <u>May 26 1983</u> , that (I) (we) last saw the deceased alive on <u>May 24 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.										
22b. SIGNATURE <u>B.H. Minchew, M.D.</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>5/28/83</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>B.H. Minchew</u>		22e. ADDRESS <u>901 BALT. NATL. Pike</u>		<u>ELICOTT CITY</u>				<u>21043</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 31, 1983		23c. NAME OF CEMETERY OR CREMATORIAL Meadowridge Mem. Park		23d. LOCATION CITY OR TOWN Dorsey, Maryland		COUNTY	STATE	
24. FUNERAL DIRECTOR NAME Donaldson Funeral Home, Laurel, Md						25a. DATE REC'D. BY REGISTRAR JUN 3 1983		25b. REGISTRAR'S SIGNATURE <u>Dot. J. Cohen</u>		
DHMH - 16 50M 1/81 (VRA 15, 4)										

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certification section should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8313593
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Mildred L. Caldwell						5-21-83				7:20 A M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		
Female		White		October 31, 1919			63			IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MD.					
Delaware		U.S.A.					Howard County,					
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
		Howard County General hospital		Retired			Oil Co.					
13a. STATE Georgia		13b. COUNTY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 550 N. HAIRSTON RD.					
		13c. CITY OR TOWN Stone Mtn.										
14. FATHER'S NAME late FIRST Frank H Neal		LAST		15. MOTHER'S MAIDEN NAME Mildred V. Andrew								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT William H. Neal			ADDRESS Ellicott City 8814 Autumn Hill Ct. 21043					
		220 05 5389										
18. CAUSE OF DEATH Enter only one cause per line for 1a, (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the breast</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first (b) <u>Metastatic Lung Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Seconds
												MONTHS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>May 17</u> , 19 <u>83</u> , to <u>May 21</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>May 20</u> , 19 <u>83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Jerry L. Lewis, M.D.</u> DEGREE												
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <u>1082 Hickory Ridge Rd, Columbia, MD 21044</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22f. DATE SIGNED <u>5-21-83</u>					
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE May 24 '83		23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park			23d. LOCATION CITY OR TOWN Baltimore Maryland		23e. COUNTY STATE			
24. FUNERAL DIRECTOR Harry H Witzke 4112 Columbia Rd Ellicott City												
25a. DATE REC'D. BY REGISTRAR <u>MAY 23 1983</u>		25b. REGISTRAR'S SIGNATURE <u>Jean J. Coniff</u>										

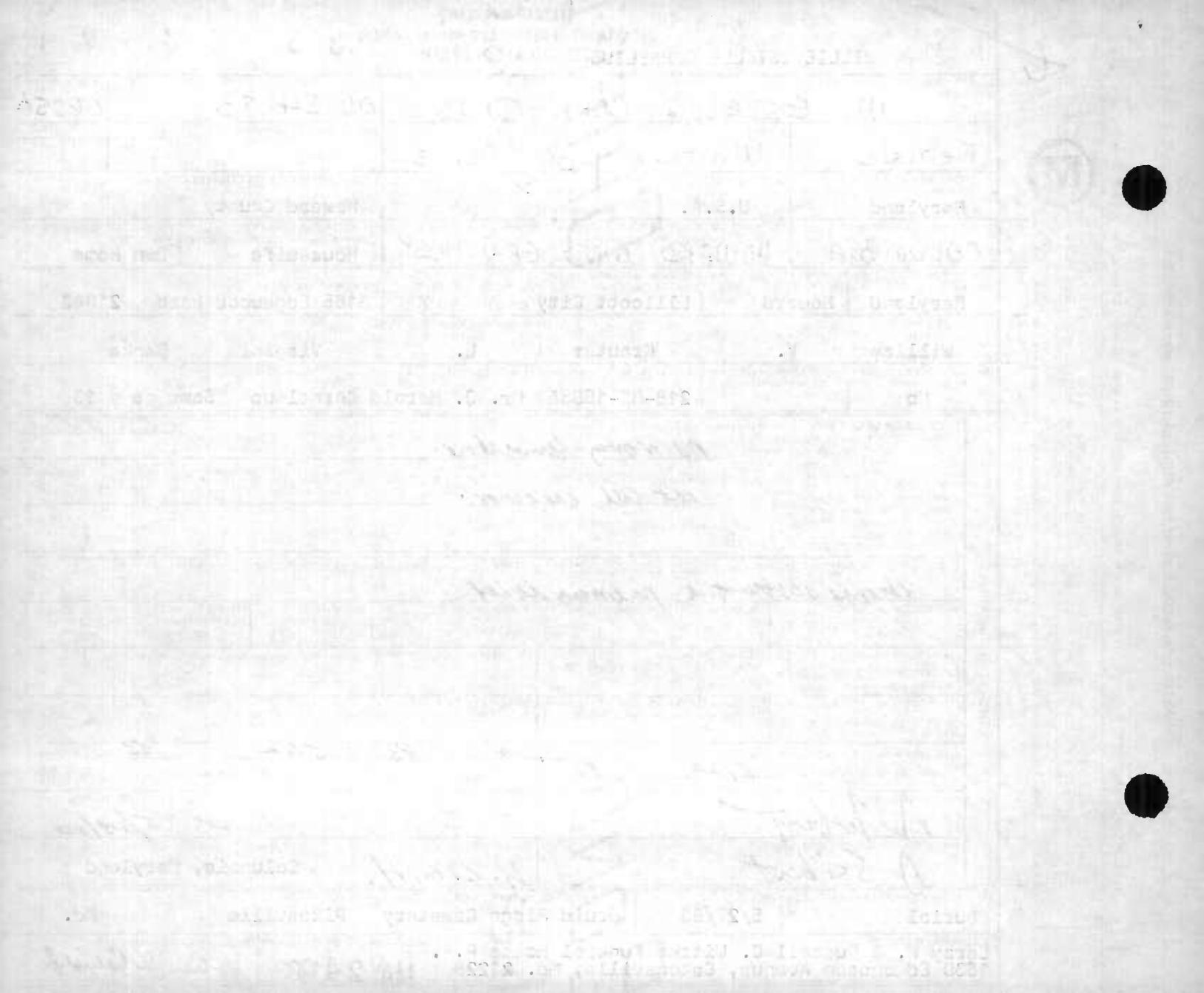
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 3 1 3 5 9 4			
WILLIE ESTELLE CORNELIUS CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
WILLIE ESTELLE CORNELIUS						05.24.83					0605A		
3. SEX Female			4. RACE White		5. DATE OF BIRTH MONTH 09 DAY 02, 1914		6. AGE (IN YEARS LAST BIRTHDAY)		68		IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County				IF UNDER 24 HRS HOURS MIN.		
10. CITY OR TOWN OF DEATH COLUMBIA			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOWARD COUNTY GEN. HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home						
13a. STATE Maryland			13b. COUNTY Howard		13c. CITY OR TOWN Ellicott City		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3165 Edgewood Road		21043		
14. FATHER'S NAME FIRST William			MIDDLE W.	LAST Krauter	15. MOTHER'S MAIDEN NAME FIRST L.		MIDDLE Virginia		LAST Banks				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 218-03-1585A		17. INFORMANT Mr. J. Harold Cornelius		ADDRESS Same as # 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Delivery Semestos</i> <i>1629</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>rat cell carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>chronic obstructive pulmonary disease</i> DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>chronic obstructive pulmonary disease</i>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>5/29</i> , 19 <i>83</i> , to <i>5/29</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED <i>5/29/83</i>	
22b. SIGNATURE <i>Dr. Seibert</i>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J. Seibert</i>		22e. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/27/83		23c. NAME OF CEMETERY OR CREMATORIAL Druid Ridge Cemetery		23d. LOCATION CITY OR TOWN Pikesville		COUNTY		STATE Md.		
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, Md. 21228			25a. DATE REC'D. BY REGISTRAR MAY 24 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Comish</i>								

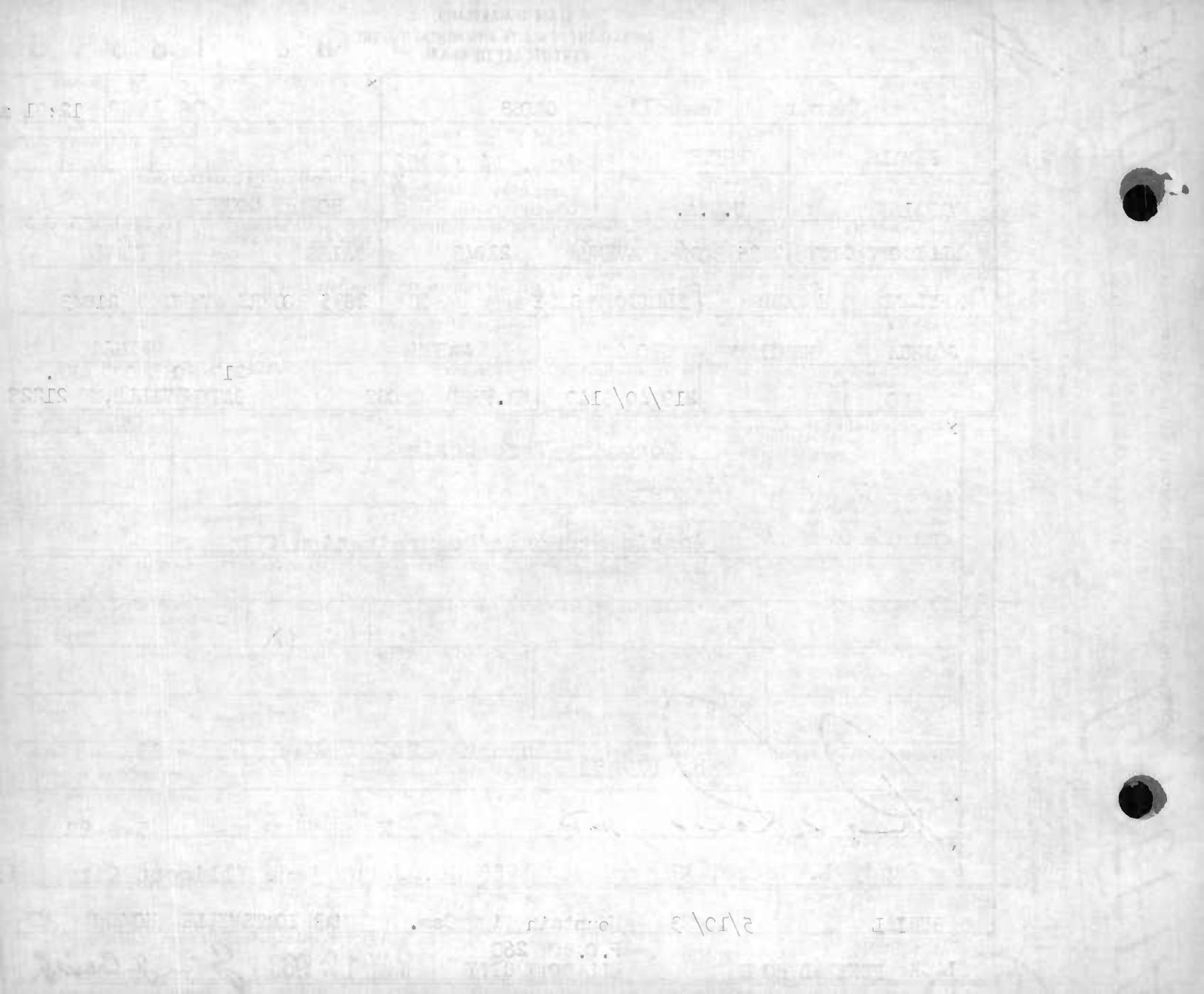


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 3	1 3 5 9 5								
												REG. NO.									
1 - FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
			Charity Isabelle CROSS												May 06 1983						12:00 AM
3 SEX			4 RACE			5. DATE OF BIRTH						6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
FEMALE			WHITE			MONTH DAY YEAR			Aug. 14 1902			80			MONTHS		DAYS		HOURS MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH									
MARYLAND			U.S.A.									HOWARD COUNTY									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY												
ELLIOTT CITY			2835 ROGERS AVENUE			21043			SALES			RETAIL									
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS									
MARYLAND			HOWARD			ELLIOTT CITY			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			2835 ROGERS AVENUE 21043									
14. FATHER'S NAME			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME												
JOSHUA			HAMILTON			CROSS			FIRST MARTHA			LAST GRIMES									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS												
NO			219/40/9140			MR. FRED CROSS			217 ROSEWOOD AVE.												
CATONSVILLE, MD 21228																					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
IMMEDIATE CAUSE (a) Coronary Thrombosis																					
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost												DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD									
												DUE TO, OR AS A CONSEQUENCE OF (c) Aortic Stenosis/Regurgitation, CHD									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?												
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE						
22a. I certify that (I) this hospital attended the deceased from now the deceased alive on			Feb 17 1983			August 19 80			to May 19 83			that (I) (we) last obtained (we) (did) (did not) view the body after death.									
22b. SIGNATURE						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)												5-6-83									
Randy L. Reese, MD												3459 St. Johns Lane Ellicott City, Md									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY			STATE						
BURIAL			5/10/83			Mountain View Cem.			MARIOTTSVILLE			HOWARD			MD						
24. FUNERAL DIRECTOR NAME			ADDRESS			P.O.BOX 268 ELLIOTT CITY			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
SLACK FUNERAL HOME									MAY 12 1983			<i>John J. Canfield</i>									

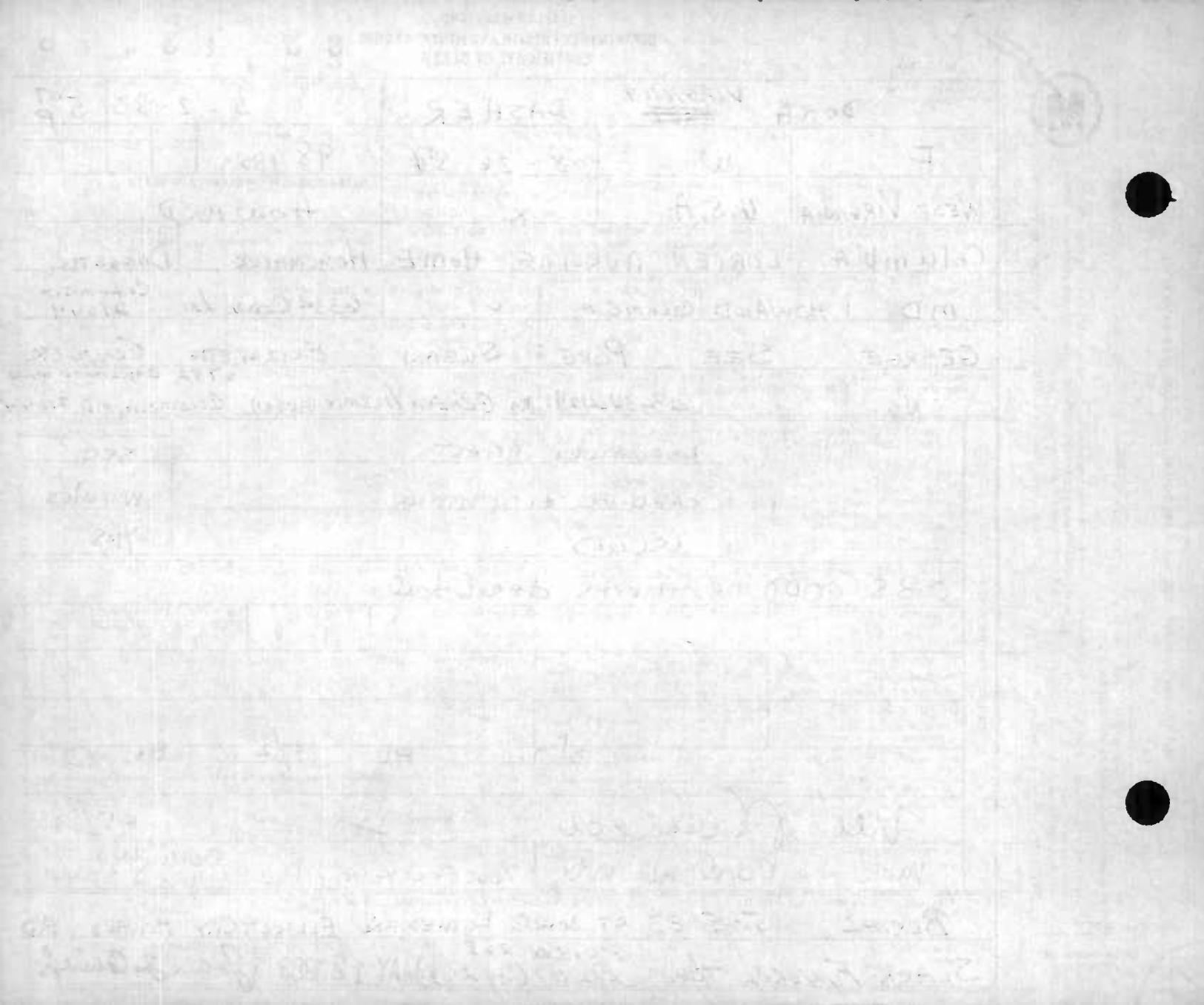


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 3 1 3 5 9 6	
												REG. NO.	
1 - STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
	DORA REED			VIRGINIA		DASHER	5 - 2 - 83				5:07 P.M.		
3 SEX	4 RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN			
F	W			08 - 26 - 84			98 yrs						
7a. BIRTHPLACE COUNTRY	7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
WEST VIRGINIA	U.S.A.						HOWARD						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
COLUMBIA	LORIEN NURSING HOME			HOMEMAKER			DOMESTIC						
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			COLUMBIA, MD 21044				
MD	HOWARD	COLUMBIA				6334 CEDAR LN.							
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			16. SOCIAL SECURITY NO.			ELIZABETH COUGER				
GEORGE	SEE	POPE	SUSAN			213-34-4291			ADDRESS 6752 OAKLAND MILLS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.			17. INFORMANT			MS. GENEVA VILMERMERHAUSEN			COLUMBIA, MD 21044			
NO													
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST 4292												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SEC	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CARDIAC ARRHYTHMIA												minutes	
{ DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD												YRS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) C.B.S, COPD, Arthritis, decubitus													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 31			19 81			to 5/2 19 83			th (I) we last saw the deceased alive on 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>Melvin Kordon MD</i>			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 4/5/83				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Melvin Kordon MD			22e. ADDRESS 2000 Century Plaza MD 21084										
23a. BURIAL, CREMATION, REMOVAL (SPEC)			23b. DATE 5 - 5 - 83			23c. NAME OF CEMETERY OR CREMATORIAL ST. JOHN'S LUTHERAN			23d. LOCATION CITY OR TOWN ELLIOTT CITY			COUNTY HOWARD	STATE MD
24. FUNERAL DIRECTOR NAME SLACK FUNERAL HOME			ADDRESS P.O. BOX 268			25a. DATE REC'D. BY REGISTRAR MAY 12 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Coniff</i>				



25
1 FOR STATE REGISTRAR

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3, RETA IN PAGE 5, FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13597

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Samuel</i>	MIDDLE <i>W.</i>	LAST <i>Dent</i>	2a. DATE KNOWN OF DEATH ESTIMATED MATERIAL	MONTH MAY	DAY YEAR	2b. HOUR 4:35A M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR		
Male	Black	4 3 1929	54 yrs.			5 21 1983	4:35P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Howard Co.			
Wash., D.C.	USA							
10. CITY OR TOWN OF DEATH Maryland	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard Co. General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Analyst, U.S. Govt. Nat. Security Agency			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland	13b. COUNTY	13c. CITY OR TOWN Columbia	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 5719 Old Buggy Ct.	21045	
14. FATHER'S NAME FIRST Frank	MIDDLE Dent	LAST	15. MOTHER'S MAIDEN NAME Ellen			Carter		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO. Yes	17. INFORMANT Mrs. Geneva Dent/wife/same as 13e			ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 5715 IMMEDIATE CAUSE (a) <i>Cardio pulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>Cirrhosis of liver, ulcerative colitis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>cause of cirrhosis is unknown</i>								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN		COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>J. Seal</i> TITLE (SPECIFY) M.D. MEDICAL EXAMINER								
EXAMINER'S NAME (TYPE OR PRINT) ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE BURIAL 5-25-83	23c. NAME OF CEMETERY OR CREMATORIAL Lincoln Memorial	23d. LOCATION CITY OR TOWN Suitland	23e. COUNTY Md.	23f. STATE Md.			
24. FUNERAL DIRECTOR NAME John T. Rhines Co.,	ADDRESS 3015 12th St. N.E., D.C. 20001	25a. DATE REC'D. BY REGISTRAR JUN 1 1983			25b. REGISTRAR'S SIGNATURE <i>John D. Cawley</i>			
DHMH - 17 (VR A15 ME(5)) 30M 7/73								

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JULY 1 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows only injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8	3	1	3	5	9	8				
					REG. NO. 13598										
1 - FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
		John A. Dolan							May		16	1983		M	
3 SEX		4. RACE		5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR		8 IF UNDER 24 HRS.				
Male		Caucasian		MONTH June DAY 16, YEAR 1895			87 YRS		MONTHS		DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
Scotland		U.S.A.						Howard County MD							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Columbia		Lorien Nursing Home			store clerk			grocery store							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		21029				
Md.		Howard		Clarksville					11501 Johns Hopkins Road						
14. FATHER'S NAME		FIRST late John	MIDDLE	LAST Dolan	15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.		17. INFORMANT		Maconachie			
					Mary			182-03-0266A		Jean Magurny Clarksville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		IMMEDIATE CAUSE (a) <i>cardiac arrest</i>													
4289		DUE TO, OR AS A CONSEQUENCE OF (b) <i>cardiac failure</i>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>5/10/83</i> to <i>5/11/83</i> , that (I) (we) lost sow, the deceased alive on <i>5/10/83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					22b. SIGNATURE <i>Gary Prode</i>		DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>5/11/83</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS <i>9380 Alt. Rd & Pk. EC 21043</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY	STATE					
Burial		May 18, 1983		Crestlawn			Ellicott City,			Md.					
24. FUNERAL DIRECTOR NAME		4112 Columbia Rd. Ellicott City, Md.			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
Harry H. Witzke					MAY 17 1983		<i>John J. Canfield</i>								

Amesbury 9897 YAH

old man still
with much

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use on the burial-trust affidavit. Then please remove carbon paper. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be informed.

MEDICAL CERTIFICATION

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8313599
REG. NO.

1. DECEASED NAME (TYPE OF PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR					
<i>George W. Dorsey</i>						<i>May 5, 1983</i>				<i>105 P.M.</i>					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN			
<i>Male</i>		<i>Caucasian</i>		MONTH	DAY	YEAR	<i>78</i>								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				10b. KIND OF BUSINESS OR INDUSTRY	
<i>Md.</i>		<i>U.S.A.</i>					<i>Howard County</i>			<i>Carpenter</i>				<i>Building</i>	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			13. ADDRESS					
<i>Columbia</i>		<i>Howard County General Hos.</i>					<i>2400 Thompson Drive</i>			<i>21104</i>					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS					
<i>Md.</i>		<i>Howard</i>		<i>Mariottsville</i>											
14. FATHER'S NAME		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.		17. INFORMANT		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
<i>DAVID</i>		<i>A.</i>	<i>Dorsey</i>	<i>Edith</i>			<i>214-14-7628</i>		<i>Katherine Dorsey</i>		<i>21104</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. IMMEDIATE CAUSE (a)		16c. WITH SUBSEQUENT EXTENSION			17. ADDRESS								
<i>No</i>		<i>4349</i>		<i>Brainstem infarction</i>			<i>Mariottsville, Md.</i>		<i>9 days</i>						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c) PART I. DEATH WAS CAUSED BY		19. IMMEDIATE CAUSE (a)		20. DUE TO, OR AS A CONSEQUENCE OF			21. DUE TO, OR AS A CONSEQUENCE OF		22. DUE TO, OR AS A CONSEQUENCE OF						
				<i>b)</i>											
				<i>c)</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
							<input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. _____ 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED <i>WHILE AT HOME</i> <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>July 1, 1980</i> , to <i>May 5, 1983</i> , that (I) (we) last saw the deceased alive on <i>May 5, 1983</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did/did not view the body after death.															
22b. SIGNATURE <i>Brad J. Cooper, MD</i>				22c. DEGREE			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS <i>3459 ST. JOHN'S LANE</i>		22f. DATE SIGNED <i>5/5/83</i>				
22d. PHYSICIAN'S NAME (TYPE OF PRINT)		23a. BURIAL, CREMATION, REMOVAL		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY	23f. STATE					
<i>BRAD J. COOPER, MD</i>		<i>Burial</i>		<i>5-9-83</i>	<i>Mt. View Cemetery</i>		<i>Mariottsville</i>		<i>Howard</i>	<i>Md.</i>					
24. FUNERAL DIRECTOR NAME		25a. ADDRESS		25b. DATE REC'D. BY REGISTRAR		25c. REGISTRAR'S SIGNATURE									
<i>Harry W. Height Sykesville, Md.</i>				<i>MAY 6 1983</i>		<i>John G. Lewis</i>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

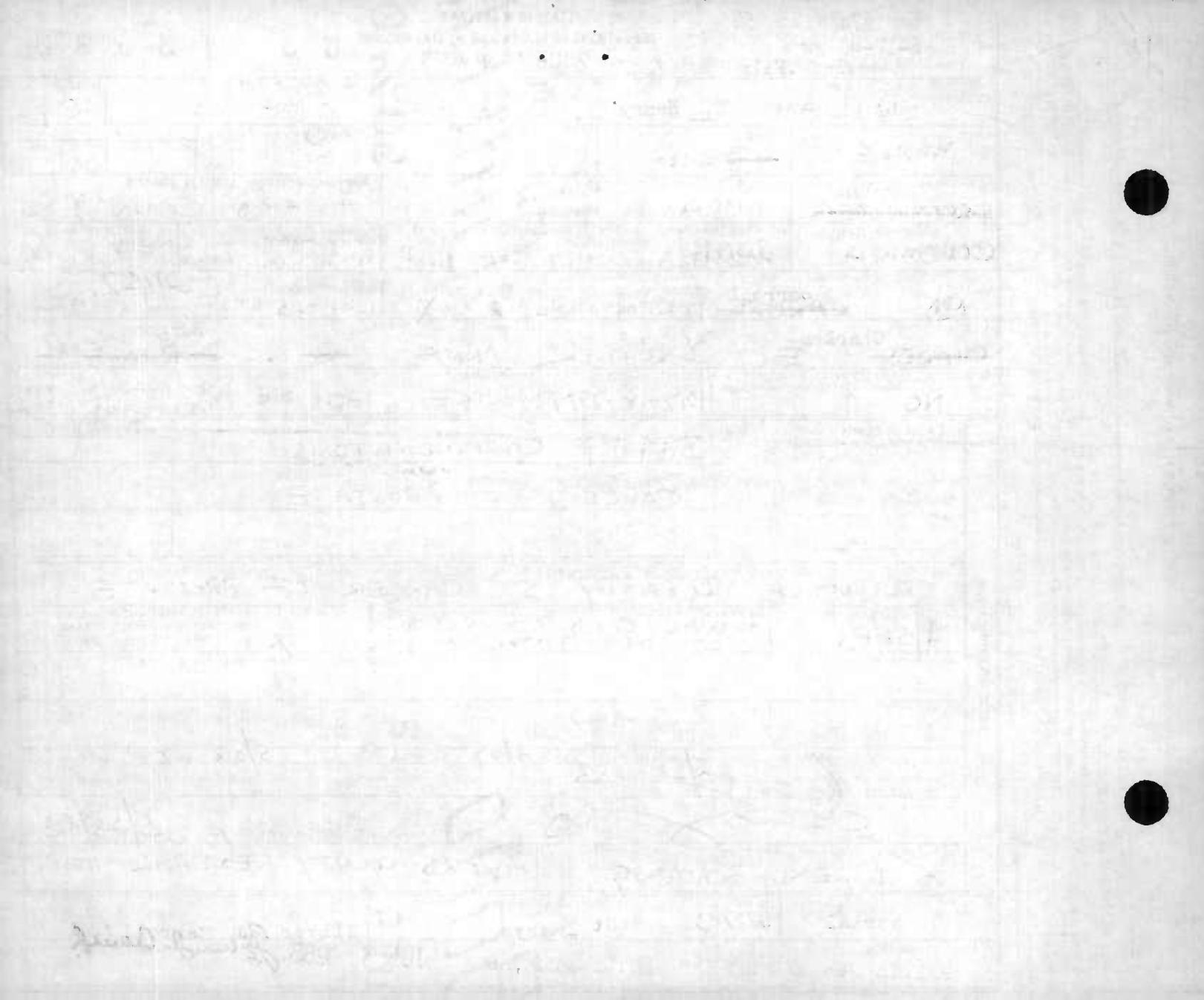
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

Item #7a Film G580

FOR STATE 6-17-83 gw
REGISTRAR Add. Info. Film G580 6/28/83 RAMSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 3 1 3 6 0 0
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
WILLIAM Henry DRECHSLER						5/28/83				10 PM		
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
MALE		E White	MONTH	DAY	YEAR	60 YRS.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY MD.				
Maryland WESTMINSTER		USA										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
COLUMBIA		HOWARD COUNTY GEN. HOSP.			PARTS COUNTERR			TRUCKING				
13a. STATE MD		13b. COUNTY CARROLL		13c. CITY OR TOWN WESTMINSTER		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1201 Old Westminster Pke		21157		
14. FATHER'S NAME FIRST Charles MIDDLE E		15. MOTHER'S MAIDEN NAME ANNA B M. DRECHSLER			16. SOCIAL SECURITY NO. 47-18-7979		17. INFORMANT WIFE		ADDRESS Westminster Pke		Burgoon	
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		18b. IMMEDIATE CAUSE (a) 1850			18c. DUE TO, OR AS A CONSEQUENCE OF CANCER OF PROSTATE			18d. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
NO		IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF CANCER OF PROSTATE							
18e. CONDITIONS, IF ANY, WHICH GOVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST		(b)			(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION 4/28/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED SPINAL CORD COMPRESSION 2.0 METASTATIC CANCER			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 5/28 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												
22b. SIGNATURE <i>John Boateng</i>		22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input checked="" type="checkbox"/> PHYSICIAN		22d. DATE SIGNED 5/28/83					
22e. ADDRESS Howard County General Hosp.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 6/2/83		23c. NAME OF CEMETERY OR CREMATORIAL St. Marys			23d. LOCATION CITY OR TOWN Silver Spring Carroll M		COUNTY	STATE		
24. FUNERAL DIRECTOR NAME PRITTS FUNERAL HOME		ADDRESS WESTMINSTER, MD			25. DATE REC'D. BY REGISTRAR JUN 9 1983		25b. REGISTRAR'S SIGNATURE <i>John Boateng</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use on the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8313601				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2d. HOUR P M				
ETHEL L. DRESSEL					DRESSEL				5	13	83	4 P				
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH 2 DAY 2 YEAR 96			6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Howard County							
10. CITY OR TOWN OF DEATH Ellicott City			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3765 Spring Meadow Drive 21043			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home							
13a. STATE Md			13b. COUNTY Howard			13c. CITY OR TOWN Ellicott City			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 3765 Spring Meadow Drive 21043				
14. FATHER'S NAME FIRST George MIDDLE Erek LAST			15. MOTHER'S MAIDEN NAME Eleanora													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-07-1201D			17. INFORMANT Audrey N. Evans			ADDRESS Same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 1539 IMMEDIATE CAUSE (a) <i>metastatic adenocarcinoma of colon</i>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b)																
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>1982</i>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <i>1982</i> , 19 <i>83</i> , to <i>May 13</i> , 19 <i>83</i> that <input type="checkbox"/> (we) lost saw the deceased alive <i>April 83</i> , 19 <i>83</i> , and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did not view the body after death.																
22b. SIGNATURE <i>Charles R. Graham Jr.</i>			22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <i>May 15, 1983</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles Graham, Jr. M.D.			22e. ADDRESS 299 Frederick Road Baltimore, Md. 21229													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 5/17/83			23c. NAME OF CEMETERY OR CREMATORIUM Westview Crematory			23d. LOCATION CITY OR TOWN Catonsville			COUNTY Balto				
24. FUNERAL DIRECTOR NAME <i>Witzke, P.A.</i> ADDRESS 1630 Edmondson Ave Catonsville, Md. 21228						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>John J. Casper</i>			STATE Md							

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10.11.15 - week 12 assignment

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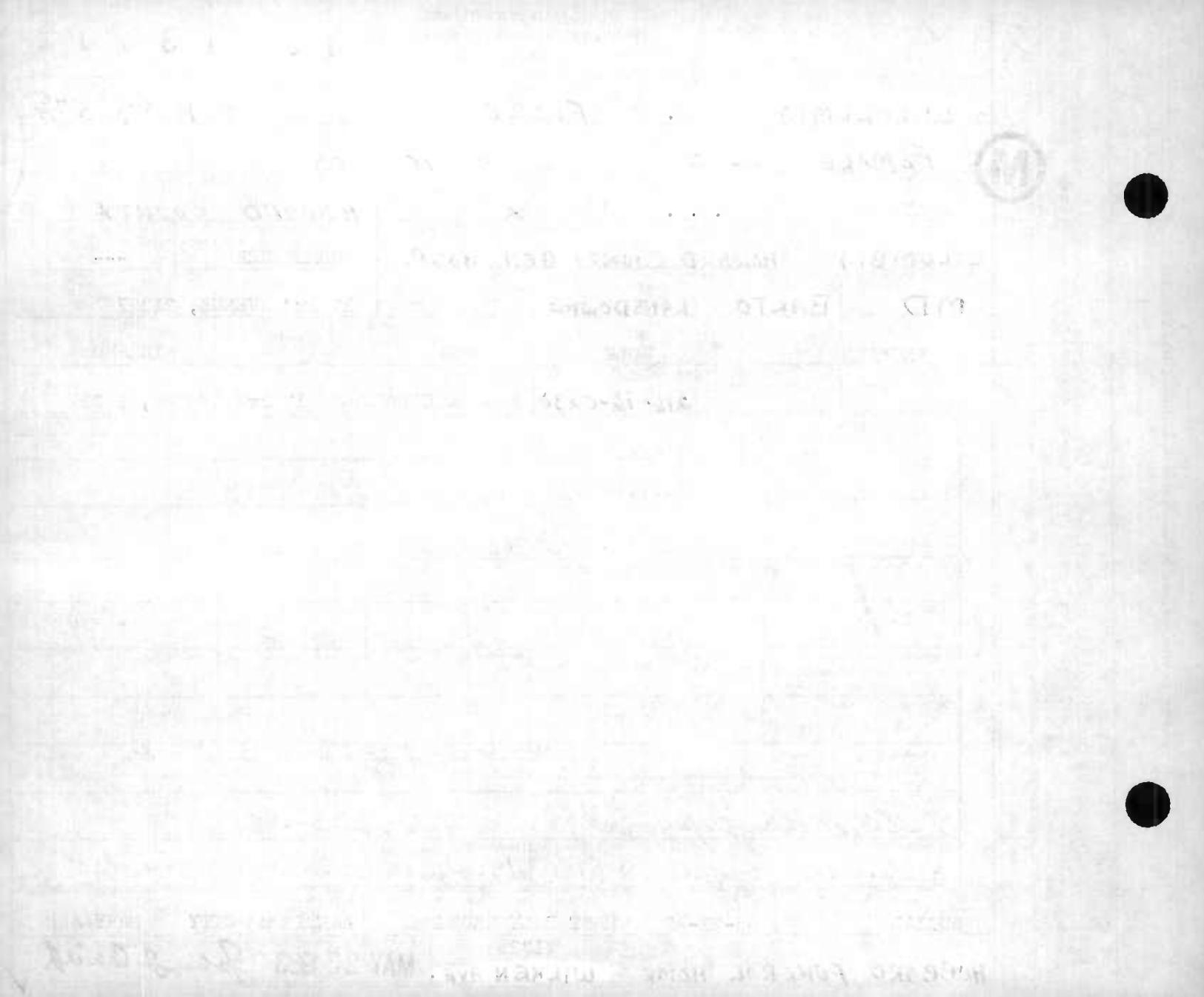
Kingsbury 20091 AM 2012-01-01 10:00:00-05:00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
WILHELMINA E. FIORE							5	19	83	5 46	PM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS				
FEMALE		WHITE		2 9 98			85			IF UNDER 24 HRS HOURS MIN.				
BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.				
MARYLAND		U.S.A.					HOWARD COUNTY MD.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
COLUMBIA				HOWARD COUNTY GEN. HOSP.						HOMEMAKER			---	
13a. STATE MD				13b. COUNTY BALTO		13c. CITY OR TOWN LANSDOWNE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 12 3rd AVENUE, 21227			
14. FATHER'S NAME LEONARD				MIDDLE		LAST		15. MOTHER'S MAIDEN NAME ROSA			LAST WIELAND			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ROSE REINSFELDER			ADDRESS 12 3rd AVENUE, 21227			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
NO		216-12-0230												
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cardiac Arrest -</i> <i>0389</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pulmonary Embolism.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.														
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Sepsis - Congestive Heart Failure</i>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <i>June 19 76</i> to <i>May 18 83</i> , that (I) (we) last saw the deceased alive on <i>May 18 83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>Alejandro Mejia MD</i>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>1900 Sulphur Spring Rd. Baltimore</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Alejandro Mejia M.D.</i>			22e. ADDRESS <i>1900 Sulphur Spring Rd. Baltimore</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 05-23-83			23c. NAME OF CEMETERY OR CREMATORIAL MOST HOLY REDEEMER			23d. LOCATION CITY OR TOWN BALTIMORE CITY			COUNTY MARYLAND STATE		
24. FUNERAL DIRECTOR NAME <i>Hubbard Funeral Home</i>			ADDRESS 21229 4107 Wilkens Ave.			25a. DATE REC'D. BY REGISTRAR MAY 23 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Carroll</i>					

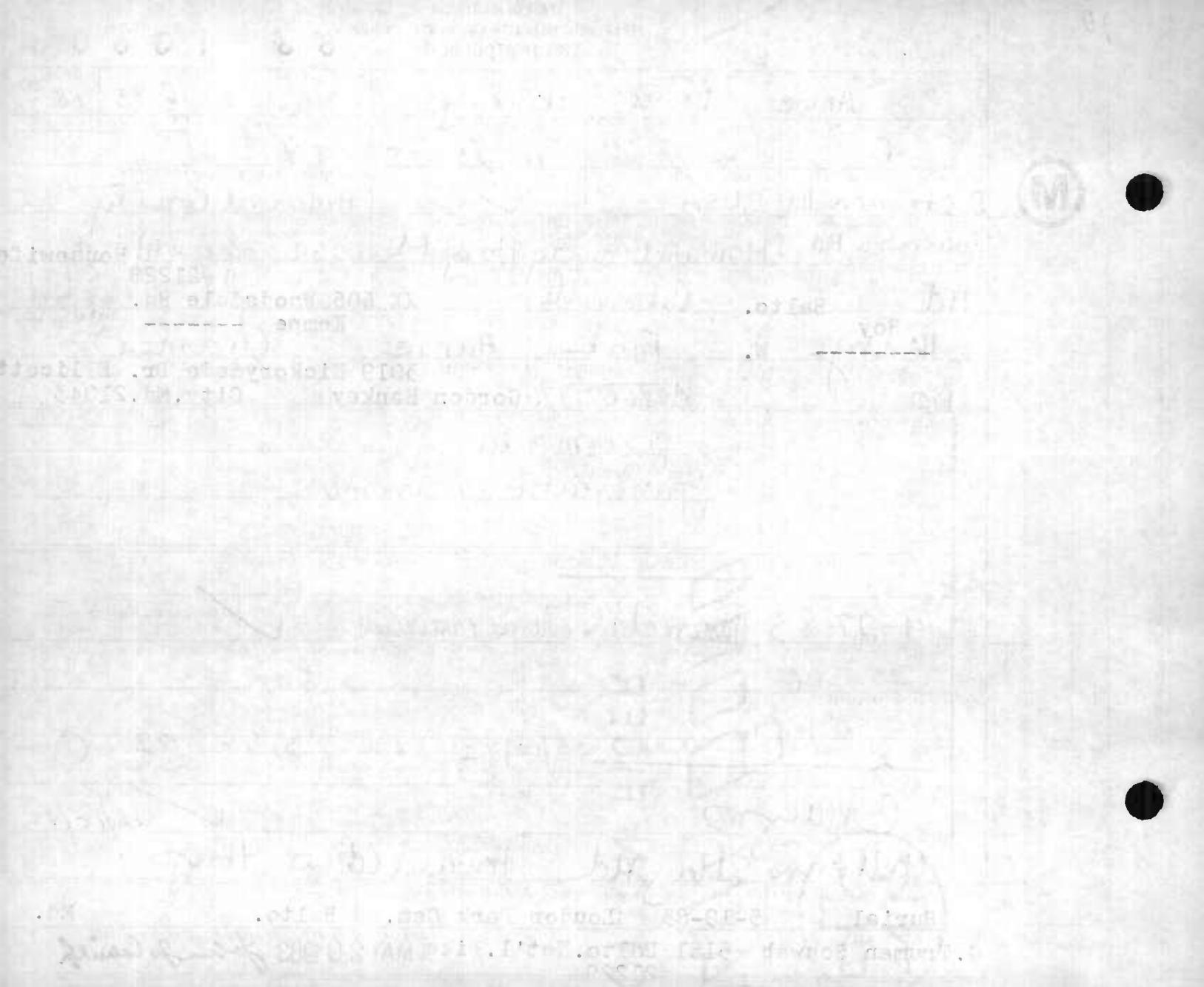


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner shall be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.					
1 - FOR STATE REGISTRAR			8 3 1 3 6 0 3														
1 DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR		
Annie Louise Hankey												5 16 83			18 30 M		
1 SEX <i>F</i>			4 RACE <i>W</i>			5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS		
						11 23 98			84			YRS			MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Baltimore Md</i>			7b CITIZEN OF WHAT COUNTRY? <i>USA</i>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH <i>Howard County</i>			10 CITY OR TOWN OF DEATH <i>Columbia Md</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Howard County Hospital</i>		
12a USUAL OCCUPATION <i>606 Woodsdale Rd Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>606 Woodsdale Rd. Maryland</i>			13a STATE <i>Md</i>			13b. COUNTY <i>Baltimore</i>			13c. CITY OR TOWN <i>Balto.</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME <i>Roy</i>			15 MOTHER'S MAIDEN NAME <i>Annie</i>			16 SOCIAL SECURITY NO. <i>0216077971</i>			17 INFORMANT <i>Gordon Hankey</i>			18a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES <i>no</i>			18b APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18c CAUSE OF DEATH Enter only one cause per line for 1a, 1b, and 1c PART I. DEATH WAS CAUSED BY: <i>1579</i>			18d IMMEDIATE CAUSE (a) <i>pneumonia</i>			18e DUE TO, OR AS A CONSEQUENCE OF - (b) <i>pancreatic carcinoma</i>			18f DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																	
19a DATE OF OPERATION <i>4-27-83</i>			19b CONDITION FOR WHICH OPERATION WAS PERFORMED <i>pancreatic & colonic carcinoma</i>			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>no</i>			21c TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21d. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <i>5/16/83</i> , 19, to <i>5/16</i> , 1983, that (I) (we) saw the deceased alive on <i>5/16/83</i> , 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>C. Maym</i>			22c. DEGREE			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <i>Catherine S. May Md</i>			22e. ADDRESS <i>Howard County Hosp.</i>			22f. DATE SIGNED <i>5/16/83</i>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>5-19-83</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Loudon Park Cem.</i>			23d. LOCATION CITY OR TOWN <i>Balto.</i>			23e. COUNTY <i>Md.</i>					
24. FUNERAL DIRECTOR <i>G. Truman Schwab</i>			25a. DATE REC'D. BY REGISTRAR <i>MAY 20 1983</i>			25b. REGISTRAR'S SIGNATURE <i>John J. Cooney</i>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8313604					
1. DECEASED NAME				FIRST	MIDDLE	LAST	2a. DATE OF DEATH				MONTH	DAY	YEAR	2b. HOUR			
<i>Rose</i>						<i>Haynes</i>	5 5 83							M			
3. SEX				4. RACE	Black	5. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.		
Female				Black	11 24 13	69				YRS							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?			8	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH				MD.			
Md.				USA						Howard Co.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY						
Columbia				Howard Co. General			Retired								21045		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS							
Md.		Howard		Columbia						7080 Cradle Rock Way							
14. FATHER'S NAME				FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME				FIRST	MIDDLE	LAST				
Allen				J.		Haynes	Minerva						Hooper				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.			17. INFORMANT				ADDRESS				21045		
No.				059-12-8971			Emily Billy				5886 Steven Forest Rd.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Breast</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1yr</i>					
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>March 19, 1983</i> , to <i>May 5, 1983</i> , that (I) (we) last saw the deceased alive on <i>May 4, 1983</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>Richard W. Smith M.D.</i>												DEGREE					
22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>5/5/83</i>														
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Richard W. Smith M.D.</i>			22e. ADDRESS <i>5999 Harpers Farm Rd Columbia Md. 21044</i>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>5/10/83</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Harmony Mem.</i>			23d. LOCATION CITY OR TOWN <i>LandOver P.G. Md.</i>								
24. FUNERAL DIRECTOR NAME <i>Chas.A. Rice FSPA</i>			ADDRESS <i>1300 Eutaw Place</i>			25a. DATE REC'D. BY REGISTRAR <i>MAY 16 1983</i>			25b. REGISTRAR'S SIGNATURE <i>John J. Coniglio</i>								



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 1 3 6 0 5
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH			MONTH	DAY	YEAR	2b. HOUR
<i>Kathy Leean Holland</i>						<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5	30	85	12:00 M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR
Female	Black	6 6 1956	68			<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5 - 30	1983	20	20 M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
35 Md.	U.S.A.						<i>Howard</i>					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
35 Simpsonville	6549 Freetown Rd					Housewife			21150			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS						
35 Md.	Howard	Simpsonville	YES <input type="checkbox"/>			6549 Freetown Rd.						
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
CHARLES F. KOSH, Sr.			EMMA HOWARD						Willard Holland (husband) #13 same as			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.			16c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
No												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I DEATH WAS CAUSED BY:												
1579 IMMEDIATE CAUSE (a) <i>metastatic ca. of pancreas</i>												
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>1 year</i>												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).												
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?						
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE <i>Robert Lydick</i> M.D. TITLE (SPECIFY) <i>Medical Examiner</i> DATE SIGNED <i>5-30-83</i>												
EXAMINER'S NAME (TYPE OR PRINT) <i>Robert Lydick</i> ADDRESS <i>3921 Waltman 2043.</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE <i>Burial 6-3-83</i>	23c. NAME OF CEMETERY OR CEMATORIY <i>Hopkins Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Highland, Howard, Md.</i>		COUNTY		STATE			
24. FUNERAL DIRECTOR NAME <i>George R. Snowden</i>	ADDRESS <i>246 N. Wash. St Rockville, MD.</i>	25a. DATE REC'D. BY REGISTRAR <i>JUN 2 1983</i>			25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i>							
BP _____	DHMH - 17 (VR A15 ME (5)) 15M 7/77											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8313606			
REG. NO.															
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Sadie Mae Husson						May 23 1983						1:00 A.M.			
3. SEX			4. RACE		S. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Female			Caucasian		Jan. 31 1901	82 yrs			MONTHS	DAYS	HOURS	MIN.			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Mass.			U.S.A.			Howard County,									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Laurel			9145 Old Scaggsville Road									Housewife		Home	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			20707			
Maryland			Howard		Laurel				9145 Old Scaggsville Rd.						
14. FATHER'S NAME FIRST			LAST		15. MOTHER'S MAIDEN NAME FIRST			ADDRESS			AST				
Charles Unknown			Husson		Sarah Unknown			9145 Old Scaggsville Rd.			Wright				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES OR UNKNOWN) <input type="checkbox"/>			16b. SOCIAL SECURITY NO. (IF YES, ONLY WAR OR DATES) N/A		17. INFORMANT Lois Stone			Laurel Maryland			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
4140			034-12-8788								3 years				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Congestive heart failure									10 years			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			Due to, or as a consequence of (b) arteriosclerotic heart disease												
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						19c. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
22a. INJURY OCCURRED AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>			22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			22c. LOCATION STREET			CITY OR TOWN			COUNTY	STATE		
22d. I certify that (I) (this hospital) attended the deceased from <u>May 15</u> 19 <u>83</u> to <u>May 23</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>May 15</u> 19 <u>83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.															
22e. SIGNATURE <i>Bruce W. Gattis</i>			22f. DEGREE M.D.			22g. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22h. DATE SIGNED 5/23/83						
22i. PHYSICIAN'S NAME (TYPE OR PRINT) BRUCE W. GATTIS			22j. ADDRESS 402 MAIN ST, LAUREL, MD. 20707												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 24 may 83			23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Crem.			23d. LOCATION CITY OR TOWN Brentwood			COUNTY	STATE P.G. Md.		
24 FUNERAL DIRECTOR FLECK FUNERAL HOME, INC. 7601 Sandy Spring Rd. Laurel Md. 20707			25a. DATE REC'D. BY REGISTRAR ADDRESS MAY 27 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Gattis</i>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

#16b, Film G579 5/20/83 kam			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8 3 3 6 0 7					
FOR 1 - STATE REGISTRAR									REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
ELISABETH A. JOHN DROW							5 - 4 - 83					12 30 AM		
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
FEMALE			WHITE		MONTH 6	DAY 14	YEAR 43	39			MONTHS YRS	DAYS	HOURS HOURS	MIN MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTY) New Hampshire			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County		
10. CITY OR TOWN OF DEATH Columbia			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A HOSPITAL, GIVE STREET ADDRESS) Howard County General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Marketing			12b. KIND OF BUSINESS OR INDUSTRY						
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 14. STATE Maryland			14. COUNTY Howard		14. CITY OR TOWN Woodbine		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1403 Morgan Station Rd 21797			MD.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 010-087-341 001-32-5301		17. INFORMANT Julius Nugent			ADDRESS 1403 Morgan Sation RD 21797						
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (1a)			Probable acute infectious disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
0820 Conditions, if any, which gave rise to immediate cause (1a), stating the underlying cause last			spotted possible rocky mountain/ fever										7 days	
DUE TO, OR AS A CONSEQUENCE OF b) Possible rocky mountain/ fever														
DUE TO, OR AS A CONSEQUENCE OF c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE	
22a. I certify that (1) this hospital attended the deceased from 5/3 , 19 83 , to 5/4 , 19 83 , that (2) we lost saw the deceased alive on 5/4 , 19 83 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above (1) we did not view the body after death.													22c. DATE SIGNED 5/4/83	
22b. SIGNATURE John J. Blanch MD			DEGREE										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN J. BLANCH, MD.			22e. ADDRESS 5999 HARPERS FARM RD COLUMBIA, MD 21044											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 9, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Holy Cross			23d. LOCATION CITY OR TOWN Franklin, Merrimak, N. Hamp.			25a. DATE REC'D. BY REGISTRAR MAY 11 1983		25b. REGISTRAR'S SIGNATURE John J. Conigli
24. FUNERAL DIRECTOR NAME Harry H Witzke			ADDRESS 4112 Columbia Rd Ellicott City											

100 hours
united, forming several small groups
in 1918
number 2,621
from a single group consisting of 1000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3, RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 13608
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE KNOWN OF ESTI- DEATH MATED	<input checked="" type="checkbox"/>	MONTH	DAY	YEAR	2b. HOUR	
Richard C. Keiter Jr.						5-4-	19	83		M		
3 SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS AT BIRTHDAY) YRS.	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR 10:50 a.m.		
Male	White	May 27, 1941	41	MONTHS	DAYS	5-4-	19	83				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County					
Pennsylvania		U.S.A.										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Columbia			Howard County General Hospital			Construction Foreman			9999 17019			
13a. STATE Pennsylvania			13b. COUNTY York		13c. CITY OR TOWN Dillsburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 845 Rte 15 N. Dillsburg 17019			
14. FATHER'S NAME Richard C Keiter			15. MOTHER'S MAIDEN NAME Hazel WEntz									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 188 32 3657			17. INFORMANT Michael Keiter 845 Rte 15 N Dillsburg Pa.			ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9192 IMMEDIATE CAUSE (a) Blunt Trauma to back DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:00A 5-4- 1983			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject struck by boom of crane			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) construction site 9300 Farrow Ave., Ellicott City, Howard Co., Md.			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Dennis F. Smyth, M.D. TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER												
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			DATE SIGNED 5-4-83						
Dennis F. Smyth, M.D.			111 Penn Street, Baltimore, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 7, 1983			23c. NAME OF CEMETERY OR CREMATORY Dillsburg Cemetery			23d. LOCATION CITY OR TOWN Dillsburg			
24. FUNERAL DIRECTOR NAME Harry H Witzke			ADDRESS 4112 Columbia Rd Ellicott City			25a. DATE REC'D. BY REGISTRAR MAY 11 1983			25b. REGISTRAR'S SIGNATURE John J. Canfield			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be forwarded within 24 hours after death is reported by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within the State Dept. of Health and Mental Hygiene prior to burial or cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 3 1 3 6 0 9											
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR May 6, 1983							2b. HOUR M											
I. DECEASED NAME (TYPE OR PRINT) Hazel W. Kessler			FIRST Hazel		MIDDLE W.	LAST Kessler	6. AGE (IN YEARS LAST BIRTHDAY) 86				IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. MONTHS 0	IF UNDER 24 HRS. DAYS 0	IF UNDER 24 HRS. HOURS 0	IF UNDER 24 HRS. MIN 0						
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR March 5, 1897	7. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Howard County						
10. CITY OR TOWN OF DEATH Columbia			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Lorien Nursing Home							12a. USUAL OCCUPATION Housewife				12b. KIND OF BUSINESS OR INDUSTRY Cedar Lane							
13a. STATE Maryland			13b. COUNTY Howard		13c. CITY OR TOWN Columbia		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS Lorien Nursing Home Cedar Lane										
14. FATHER'S NAME late FIRST Edward			MIDDLE Wetmore	LAST	15. MOTHER'S MAIDEN NAME late FIRST Jenny Adams																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 150 03 5636 D			17. INFORMANT Mrs James Duke				ADDRESS 8210 Mercy Rd Fulton Md 20759											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart Disease - MI 4100 DUE TO, OR AS A CONSEQUENCE OF { Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET				CITY OR TOWN		COUNTY	STATE								
22a. I certify that (I) (this hospital) attended the deceased from 1 , 19 83 , to 3 , 19 83 , that (I) (we) last saw the deceased alive on 4/29/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.															22b. SIGNATURE Gary C. Pack		DEGREE MD	22c. DATE SIGNED 5/6/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gary C. Pack			22e. ADDRESS 9380 Salt Creek Pike																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE May 7, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Westview Memorial Pk				23d. LOCATION CITY OR TOWN Catonsville Maryland											
24. FUNERAL DIRECTOR Harry H Witzke			25a. DATE REC'D. BY REGISTRAR MAY 11 1983			25b. REGISTRAR'S SIGNATURE John S. Cawley															

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 3	1 3 6 1 0	REG. NO.
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
			Frank			Kidd			May 26, 1983					
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male			White			April 10, 1907			76 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland			U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Howard			MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Columbia			5919 Gales Lane Columbia, Md.			Teacher			Baltimore City					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
Maryland						Baltimore						4304 Mainfield Ave. 21214		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
Frank Kidd			Judith Epple						218-09-5887			Columbia, Md. Angela L. Flynn 5919 Gales Lane 21045		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Condrie Arleyman,</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCOV</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 wks</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET 3 19 83 CITY OR TOWN 5/26 19 83 COUNTY 23 STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>3</u> , 19 <u>83</u> , to <u>5/26</u> , 19 <u>83</u> , that (we) last saw the deceased alive on <u>2/22</u> , 19 <u>83</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.														
22b. SIGNATURE <u>Stuart Bell MD.</u>			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stuart Bell MD.			22e. ADDRESS 3501 St. Paul St. Baltimore, Md. 21218			22f. DATE SIGNED <u>5/27/83</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial May 31 1983			23c. NAME OF CEMETERY OR CREMATORIAL Most Holy Redeemer			23d. LOCATION CITY OR TOWN Baltimore COUNTY Maryland STATE					
24. FUNERAL DIRECTOR NAME Leonard J. Ruck Inc. Baltimore, Maryland			25a. DATE REC'D. BY REGISTRAR MAY 31 1983			25b. REGISTRAR'S SIGNATURE <u>John J. Conroy</u>								

6166

1981-11-11

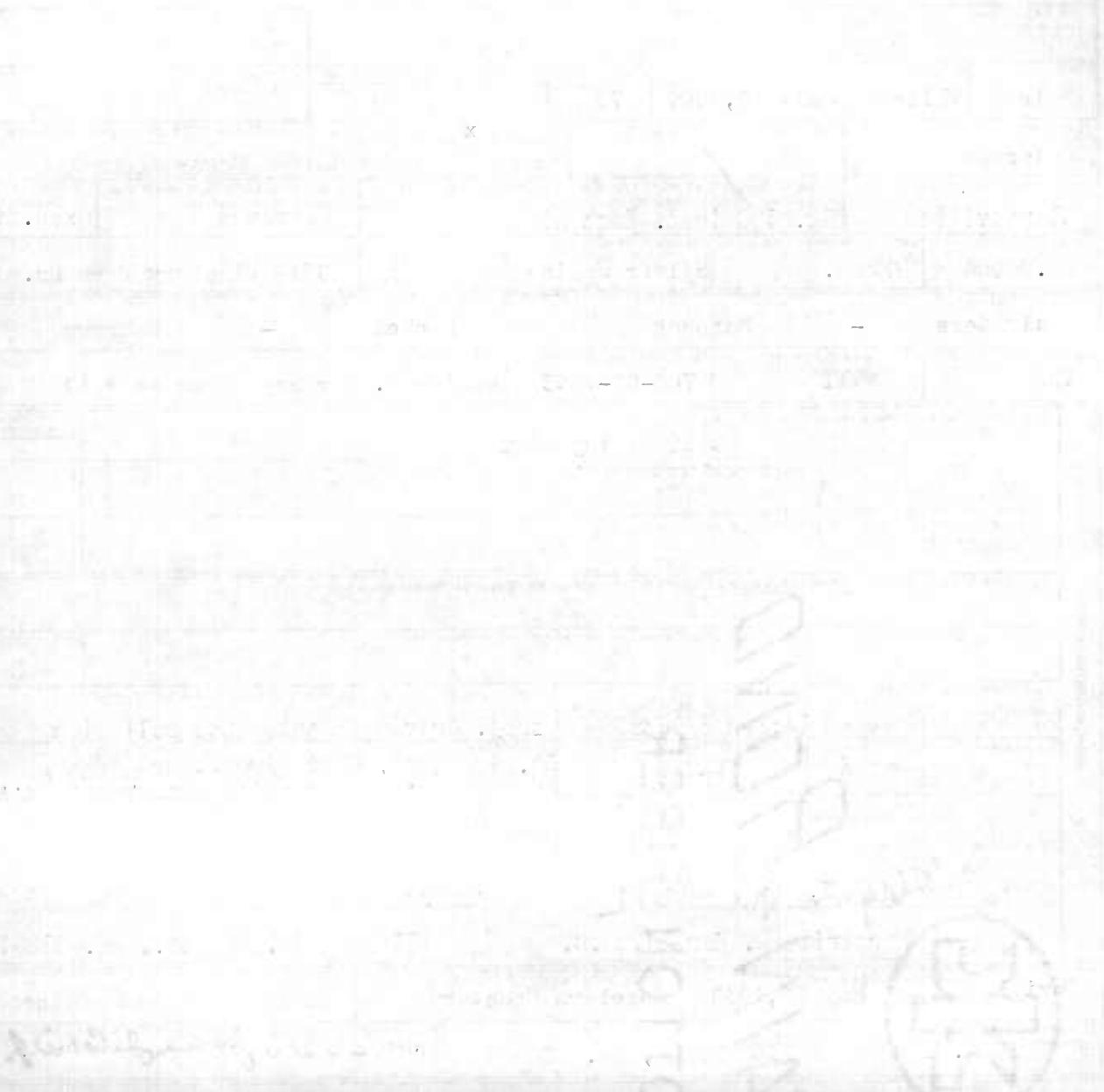
SEARCHED	X	INDEXED	SEARCHED
ALL INFORMATION			ALL INFORMATION
ALL INFORMATION	X	INDEXED	ALL INFORMATION
SIGNAL	SEARCHED	INDEXED	SEARCHED
SIGNAL			
ALL INFORMATION			

ALL INFORMATION SEARCHED INDEXED SEARCHED INDEXED

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR.
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3, RETAIN PAGE 3 WITH FORM PM-3.
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 211 PRESTON STREET, BALTIMORE, HARBOUR 21201 PRIOR TO BURIAL, Cremation, or Removal.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 3611		
1- STATE REGISTRAR			2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR 5/16/83 19									2b. HOUR 12:30 PM		
1. DECEASED NAME (TYPE OR PRINT) Ernest Anthony Maroney			MIDDLE			LAST			2c. DATE PRONOUNCED DEAD 5/16/83 19					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 19, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7. CITIZEN OF WHAT COUNTRY? USA MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Howard County	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Colorado			10. CITY OR TOWN OF DEATH Clarksville 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 108 inst. East River 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Produce 12b. KIND OF BUSINESS OR INDUSTRY Groc. Store											
13a. STATE Md. 20906			13b. COUNTY Mont.		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3719 Finsbury Park Dr. 20906					
14. FATHER'S NAME FIRST Salvatore - MIDDLE Maroney LAST			15. MOTHER'S MAIDEN NAME FIRST Rachel - MIDDLE Unknown LAST											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNKNOWN (IF YES, GIVE WAR OR DATES) WWII			16b. SOCIAL SECURITY NO. 700-01-1695			17. INFORMANT Louise C. Maroney			ADDRESS Same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <i>8/20</i> IMMEDIATE CAUSE (a) Multiple Injuries Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) } DUE TO, OR AS A CONSEQUENCE OF } (c) }												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:30x 5/16/83 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subj. driver in auto/auto collision								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street			21f. LOCATION RT. 108 Inst. East River near Trotter Rd. COUNTY Clarksville, Howard Co., Md. STATE								
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE <i>Margarita Korell</i>			TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER									DATE SIGNED 5/16/83		
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.			ADDRESS 111 Penn St., Balto., Md. 21201											
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE May 20, 1983			23c. NAME OF CEMETERY OR CREMATORY Roselawn Cemetery			23d. LOCATION COLORADO Pueblo			23e. COUNTY Pueblo COLORADO STATE		
24. FUNERAL DIRECTOR FRANCIS H. BARBER LAYTONSVILLE, MD. 20879			25a. DATE REC'D. BY REGISTRAR MAY 20 1983			25b. REGISTRAR'S SIGNATURE <i>John G. Cahill</i>								
BP														
DHMH - 17 (VR A15 ME (5))														
20M 4/B2														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other traumatic event, or other traumatic event, the medical examiner may be notified.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 1 3 6 1 2					
										REG. NO.					
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR					
I DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST		May 23, 1983			11:45pm					
Yvonne			Faye		Mellendick										
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN			
Female		White		January 4, 1922			61			YRS. 4					
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH New Market Baltimore County			MD.					
Kentucky		U.S.A.													
10 CITY OR TOWN OF DEATH Woodstock		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		10717 Davis Avenue 21163			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			Home Maker		12b. KIND OF BUSINESS OR INDUSTRY			
Maryland		13a STATE Baltimore		13b. COUNTRY CITY OR TOWN Woodstock			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 10717 Davis Avenue 21163					
Dorey A. Miller															
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT Mr. Edmund J. Mellendick, Sr.			ADDRESS								
No		214-18-7945		10717 Davis Avenue Woodstock, MD. 21163											
18 CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Poorly Differentiated Lung Carcinoma 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE				
22a. I certify that (I) the physician attended the deceased from FEBRUARY 28 19 83 to MAY 23 19 83, that (I/we) last saw the deceased alive on APRIL 29 19 83, and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) the physician did not leave the body after death.															
22b. SIGNATURE					DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5/24/83				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		Dr. Diana Griffiths			22e. ADDRESS St. Agnes Hospital										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 5-27-83		23c. NAME OF CEMETERY OR CREMATORIAL St. Alphonsus Cem.			23d. LOCATION CITY OR TOWN Woodstock			COUNTY Baltimore MD.		STATE			
Burial															
24 FUNERAL DIRECTOR NAME		Loring Byers Funeral Directors, Inc.			25a. DATE REC'D. BY REGISTRAR MAY 26 1983			25b. REGISTRAR'S SIGNATURE J. Ann G. Canfield							
		ADDRESS 8728 Liberty Road Randallstown, Maryland 21138													

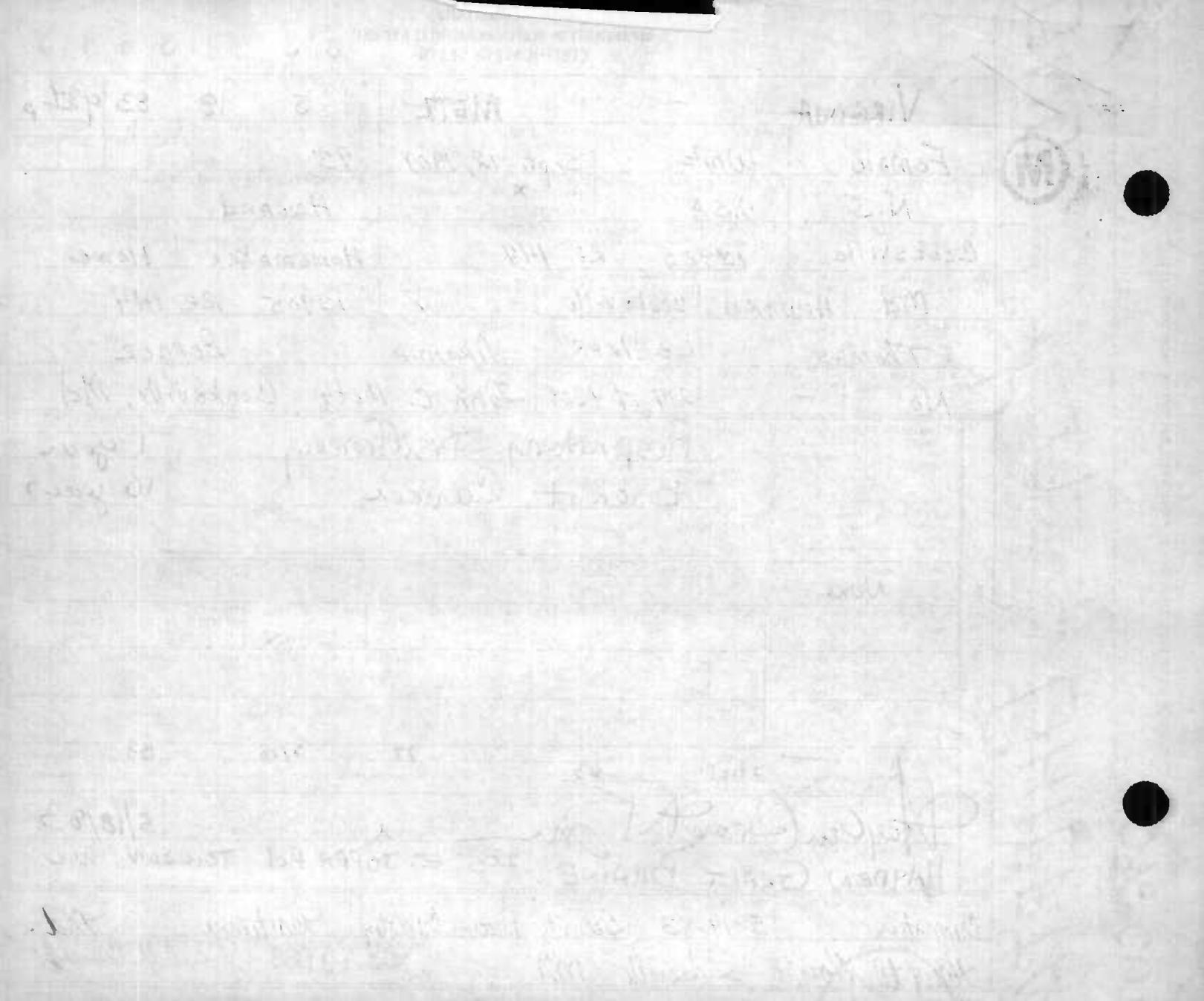
REPO WAG

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												83 13613			
												REG. NO.			
1. DECEASED, NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
VIRGINIA			-		METZ	5			18	83	9:34 PM				
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female			White	Month Day Year			73'			MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
N.J.			U.S.A.						Howard						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Cooksville			13905 Rt. 144			Homemaker			Home						
13a. STATE			13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS					
Md.			Howard	Cooksville						13905 Rt. 144 217223					
14. FATHER'S NAME FIRST			MIDDLE	15. MOTHER'S MAIDEN NAME FIRST											
Thomas			LeClear	Virginia											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No			217 13 4308			John C. Metz			Cooksville, Md.			1 year			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY			IMMEDIATE CAUSE (a)			Respiratory Insufficiency									
1749															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)			Breast Cancer						16 years			
			(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
None															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE		
22a. I certify that (I) (the hospital) attended the deceased from 19 77 to 19 78, that (I) (we) last viewed the deceased alive on 5/18/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We did not view the body after death.)															
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED						
HAYDEN GRANT BRAINE									205 E. JOPPA Rd. Towson MD			5/18/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS												
HAYDEN GRANT BRAINE			205 E. JOPPA Rd. Towson MD												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE		
Cremation			5-19-83			Security Pacific Cemetery			Baltimore						
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Henry W. Haught Sykesville, Md.						MAY 19 1983			John G. Lough						



TO HOSPITAL OR ATTENDING PHYSICIAN | The law requires that the death certificate be executed within 24 hours after death. Please mark box.

TO FUNERAL DIRECTOR | After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 1 3 6 1 4	
1 - STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b HOUR	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			5/18/83			9:59 AM		
JEAN M. NICHOLS											
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		
FEMALE			WHITE			07 14 37			45 YRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND			U.S.A.						HOWARD COUNTY		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
COLUMBIA			HOWARD COUNTY GENERAL HOSPITAL			CLERICAL			TELEPHONE CO.		
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS & ST. OF MARYLAND		
MARYLAND			HOWARD			ELLIOTT CITY			9525 JOEY DRIVE, 21043		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						ADDRESS		
GORDON GRIFFITH MARY									ELLIOTT CITY, MD.		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
NO			212-34-6332			ROBERT S. NICHOLS 9525 JOEY DRIVE, 21043					
18 CAUSE OF DEATH (Enter only one cause per line for 18, 18b, and 18c.) PART I. DEATH WAS CAUSED BY											
IMMEDIATE CAUSE (a) Respiratory Failure											
4920 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Emphysema											
{ DUE TO, OR AS A CONSEQUENCE OF											
(c) Severe desorder											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
NA											
19a DATE OF OPERATION N/A			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WHICH UNDERLYING OR CONTRIBUTED TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 5/14/83 to 5/18/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated saw the deceased alive on 5/18/83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Wilkins Flowers MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED 5/18/83		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Flowers.			22e ADDRESS Columbia Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 05-21-83			23c. NAME OF CEMETERY OR CREMATORIAL NEW CATHEDRAL			23d. LOCATION CITY OR TOWN BALTIMORE CITY COUNTY MARYLAND STATE		
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.			ADDRESS 21229			25a. DATE RECD. BY REGISTRAR MAY 20 1983			25b. REGISTRATION NO. John G. Baile		
(VRA 15 (4))											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 hours only injury, or other traumatic event, the medical examiner may be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 1 3 6 1 5	REG. NO.							
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR			
			Wilhelmina Louise Norgle								May 30, 1983			303				
3. SEX			4 RACE				5 DATE OF BIRTH MONTH DAY YEAR				6 AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR MONTHS DAYS			
Female			White				March 25, 1906				77				IF UNDER 24 HRS HOURS MIN			
7a BIRTHPLACE (COUNTRY)			7b CITIZEN OF WHAT COUNTRY?				8				MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED XX DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH			
Maryland			U.S.A.												Howard			
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)				12b KIND OF BUSINESS OR INDUSTRY							
Columbia			Howard County General Hospital				Housewife				Own Home							
13a STATE Maryland			13b COUNTY Calvert		13c CITY OR TOWN Leonard		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e STREET ADDRESS SR2 Box 360				20685			
14 FATHER'S NAME Frederick			MIDDLE		LAST		15. MOTHER'S MAIDEN NAME Elizabeth				16. ADDRESS							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO. 213 48 2888				17. INFORMANT Nancy L. Lenas				P.O. Box 34							
No											St. Leonard, Maryland 20685							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 4149										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
IMMEDIATE CAUSE (a) Cardiopulmonary Arrest																		
DUE TO, OR AS A CONSEQUENCE OF b) Pulmonary Edema																		
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last																		
DUE TO, OR AS A CONSEQUENCE OF c) Coronary Vascular Disease																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED							20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5/30 83 , to 5/30 83 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.																		
22b. SIGNATURE H. Cook			22c. DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22d. DATE SIGNED 5/30/83							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. Cook			22e ADDRESS Howard County General Hospital															
23a. BURIAL, CREMATION, REMOVAL SPECIES Burial			23b. DATE 6/2/83				23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery				23d. LOCATION CITY OR TOWN Brentwood P.G. Maryland							
24. FUNERAL DIRECTOR NAME Francis Gasch's Sons Funeral Home, P.A.			ADDRESS Hyattsville, Maryland				25a. DATE REC'D. BY REGISTRAR JUN 3 1983				REGISTRAR'S SIGNATURE John J. Coniff							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please
return by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours
with the State Dept. of Health and Mental Hygiene prior to burial, removal, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	8 3 1 3 6 1 6		
1 - STATE REGISTRAR		1. DECLARED NAME John O. Novotny				LAST <i>Novotny</i>		20. DATE OF DEATH MONTH DAY YEAR 5/9/83		2b HOUR 9 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6/11/02		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 80		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST PAYING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY -			
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF MORE THAN FACILITY, GIVE STREET ADDRESS) Haven Nursing Home				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. ADDRESS Titusville, Florida		13b. ADDRESS 1525 Thornton Ave. 32780			
13a. STATE Florida		13b. COUNTY Titusville		13e. CITY OR TOWN Titusville		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Kremel		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-18-5132A		17. INFORMANT ADDRESS John Novotny 2210 Erdman Avenue 21213	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY 4360 IMMEDIATE CAUSE (a) CVA (stroke)													
DUE TO, OR AS A CONSEQUENCE OF (b) arachnoiditis													
DUE TO, OR AS A CONSEQUENCE OF (c) -													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cystic fibrosis				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) -		21f. LOCATION STREET -		CITY OR TOWN -		COUNTY -		STATE -			
22a. I certify that (I) (this hospital) attended the deceased from 5/7/83 to 5/7/83 , that (I) (we) last saw the deceased alive on 5/7/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 5/15/83	
22b. SIGNATURE Gary C Prady		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gary C Prady				22e. DEGREE -		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-11-83		23c. NAME OF CEMETERY OR CREMATORIAL New Cathedral Cem.		23d. LOCATION CITY OR TOWN Baltimore, Md.		23e. COUNTY -		23f. STATE -			
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. ADDRESS 3331 Brehms Lane, Baltimore, Md. 21213		25a. DATE REC'D. BY REGISTRAR MAY 10 1983		25b. REGISTRAR'S SIGNATURE John J. Cane									

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10 HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

11 FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/master permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 23 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8 3 13617
1. DECEASED NAME (TYPE OR PRINT)			FIRST MARY	MIDDLE LOU	LAST OAKLEY	2a. DATE OF DEATH MONTH YEAR 5 23 1983			DAY HOUR 12:30 P.M.	MONTH YEAR IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH MONTH 8 DAY 30 YEAR 1937			6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON D.C.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY			
10. CITY OR TOWN OF DEATH JESSUP			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8414 MISSION RD.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DOMESTIC			12b. KIND OF BUSINESS OR INDUSTRY CLEAN. SRV.			
13a. STATE MARYLAND			13b. COUNTY HOWARD			13c. CITY OR TOWN JESSUP			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST EDWIN			MIDDLE LEAN			LAST STONE			15. MOTHER'S MAIDEN NAME FIRST MARY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 577/50/2356			17. INFORMANT MS. EILEEN SHIELDS			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 21044			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) RESPIRATORY FAILURE												
<p>1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> <p>(b) SQUAMOUS CELL CARCINOMA OF LUNG</p> <p>(c) EMPHYSEMA</p>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) HYPERTENSION, PEPTIC ULCER DISEASE												
19a. DATE OF OPERATION 4/14			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED x/13			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 4/14			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 4/14 19 83			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 4/14						
21d. INJURY OCCURRED <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 4/14			21f. LOCATION STREET JULY 1 4/14 CITY OR TOWN 19 80 TO MAY 23 19 83 COUNTY STATE						
22a. I certify that (I) this hospital attended the deceased from MAY 22 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) we did (did not) view the body after death.												
22b. SIGNATURE <i>Randy L. Reeser</i>			22c. DEGREE MO			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 5/25/83			
22f. PHYSICIAN'S NAME (TYPE OR PRINT) Randy L. Reeser			22g. ADDRESS 3459 ST. JOHNS LANE ELLIOTT CITY MD, 21043									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 5/26/83			23c. NAME OF CEMETERY OR CREMATORIAL MEADOWRIDGE MEM.PK.			23d. LOCATION CITY OR TOWN ELKRIDGE COUNTY HOWARD STATE MD			
24. FUNERAL DIRECTOR NAME SLACK FUNERAL HOME			P.O. BOX 268 ADDRESS ELLIOTT CITY, MD			25a. DATE REC'D. BY REGISTRAR 21 MAY 31 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Carroll</i>			

EX-73-102

EX

EX-73-102

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EX-73-102

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EX-73-102

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
8 3 1 3 6 1 8 REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	
<i>Margaret Beatrice OTT</i>						5 19 83						
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			2b. HOUR		
<i>Female</i>		<i>White</i>		<i>18 98 MARCH 18 1900</i>			<i>89 yrs.</i>			<i>6 25 AM</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH, <i>Howard County</i>	
<i>Maryland</i>		<i>G.S.A.</i>										
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
<i>Columbia</i>		<i>Howard County General Hosp.</i>						<i>Housewife</i>			<i>MD.</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE <i>Md.</i>		13b. COUNTY <i>Carroll</i>		13c. CITY OR TOWN <i>Westminster</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>27 Timber Ridge 21157</i>				
14. FATHER'S NAME FIRST <i>George</i>			MIDDLE <i>Trott</i>	LAST	15. MOTHER'S MAIDEN NAME FIRST <i>Susanna Arizona</i>			MIDDLE <i>Dawer</i>	LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. <i>214-16-1746</i>			17. INFORMANT <i>Linda Koers</i>			12a. ADDRESS <i>Priani Ave Westminster Md. 21151</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory arrest</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>seconds MIN</i>												
4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>probable sepsis 2nd pneumonia</i> 1d. (c) <i>CVA, comatose state</i> 7d.												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Ascedi, pacemaker, atrial fibr, decompens</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>9/17</i> , 19 <i>83</i> , to <i>5/19</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>5/18</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.												
22b. SIGNATURE <i>Melvin J Kordon MD</i>		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>5/29/83</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Melvin J Kordon</i>		22e. ADDRESS <i>2000 Century Plaza Columbia MD 21044</i>										
23a. BURIAL, CREMATION, REMOVAL (IF ANY) <i>Burial</i>		23b. DATE <i>5-23-1983</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Evergreen Mem. Gardens</i>			23d. LOCATION CITY OR TOWN <i>Fairfax</i>			COUNTY <i>Carroll</i>		
24. FUNERAL DIRECTOR NAME <i>Jeb Hatch</i>		25a. DATE OF DEATH <i>254 E. Main St.</i>			25b. ADDRESS <i>Westminster Md. 21157</i>			25c. DATE OF DEATH <i>MAY 23 1983</i>			25d. SIGNATURE <i>John J. Gossage</i>	



PRINTED IN U.S.A.

EGG'S YAM

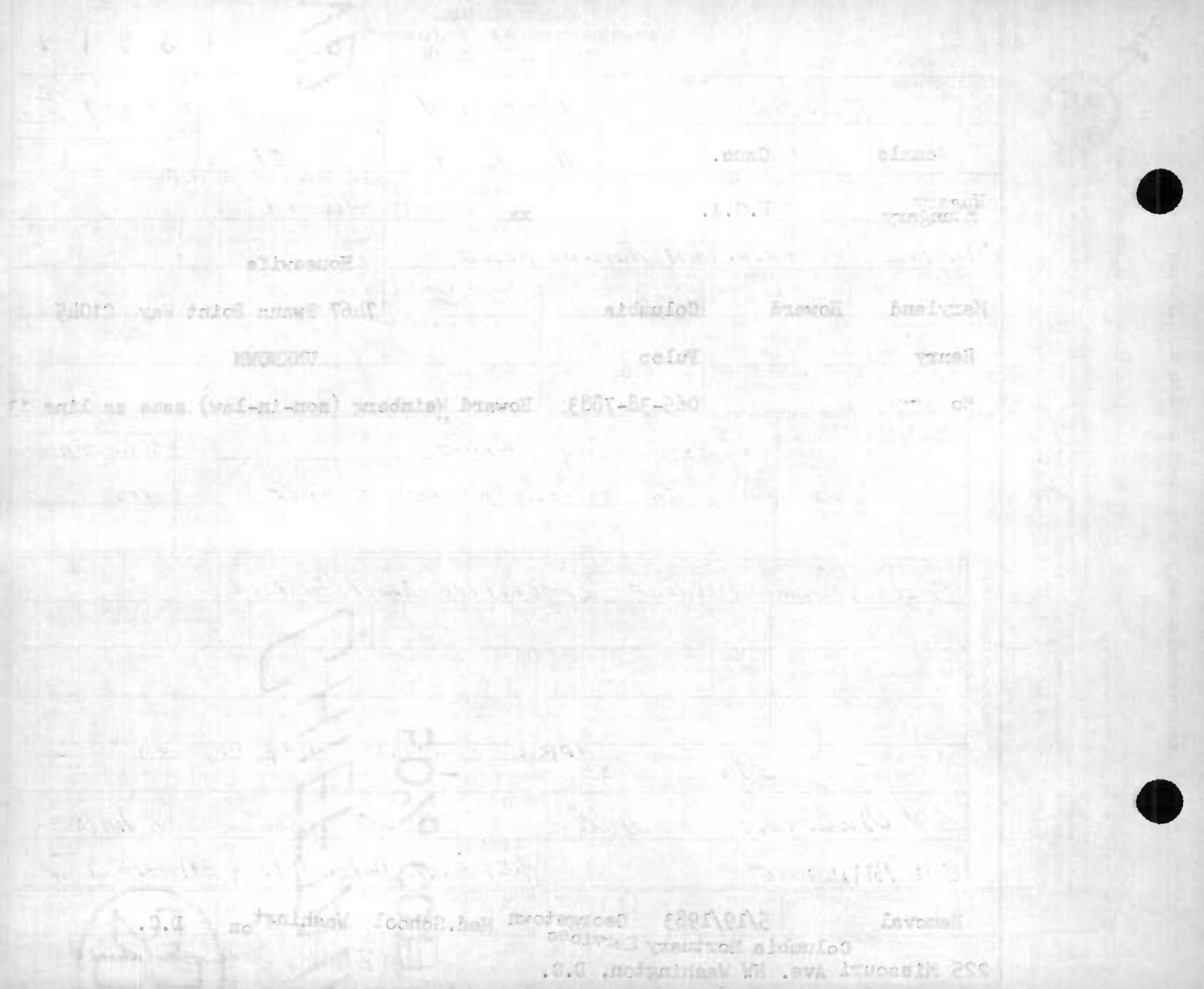
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please notify.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit Permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified or he will be notified of death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
8 3 3 6 9 REG. NO.											
1 - FOR STATE REGISTRAR			FIRST			MIDDLE			LAST		
I. DECEASED NAME (TYPE OR PRINT)			<i>KATHLYN</i>						<i>PATTISON</i>		
3. SEX <i>Female</i>			4. RACE <i>Cauc.</i>			5. DATE OF BIRTH MONTH <i>11</i>			DAY <i>16</i> YEAR <i>01</i>		
7a. BIRTHPLACE (COUNTRY) <i>Hungary</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Howard</i>		
10. CITY OR TOWN OF DEATH <i>Columbia</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Lorien Nursing Home</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Howard</i>			13c. CITY OR TOWN <i>Columbia</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST <i>Henry</i>			MIDDLE <i>Fulop</i>			LAST			15. MOTHER'S MAIDEN NAME FIRST <i>Howard</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. <i>065-38-7883</i>			17. INFORMANT <i>Howard Weinberg (son-in-law) same as line 13</i>			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>SIMULTANEOUS</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>RESPIRATORY Arrest</i> <i>4960</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>Chronic obstructive pul. Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <i>CEREROVASCULAR Accident; congestive heart failure</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>APRIL 19, 1983</i> , to <i>MAY 19, 1983</i> , that (I) <input type="checkbox"/> lost saw the deceased alive on <i>5/16 1983</i> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>B. H. Minchew,</i>			22c. DEGREE <i>M.D.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>5/19/83</i>		
22e. ADDRESS <i>9051 Balt. Natl. Pike; Ellicott City</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>			23b. DATE <i>5/19/1983</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Georgetown Med. School</i>			23d. LOCATION CITY OR TOWN <i>Washington</i> COUNTY <i>D.C.</i> STATE		
24. FUNERAL DIRECTOR NAME <i>Columbia Mortuary Services</i>			ADDRESS <i>225 Missouri Ave. NW Washington, D.C.</i>			25. DATE REC'D. BY REGISTRAR <i>MAY 26 1983</i>			26. REGISTRAR'S SIGNATURE <i>John J. Connel</i>		



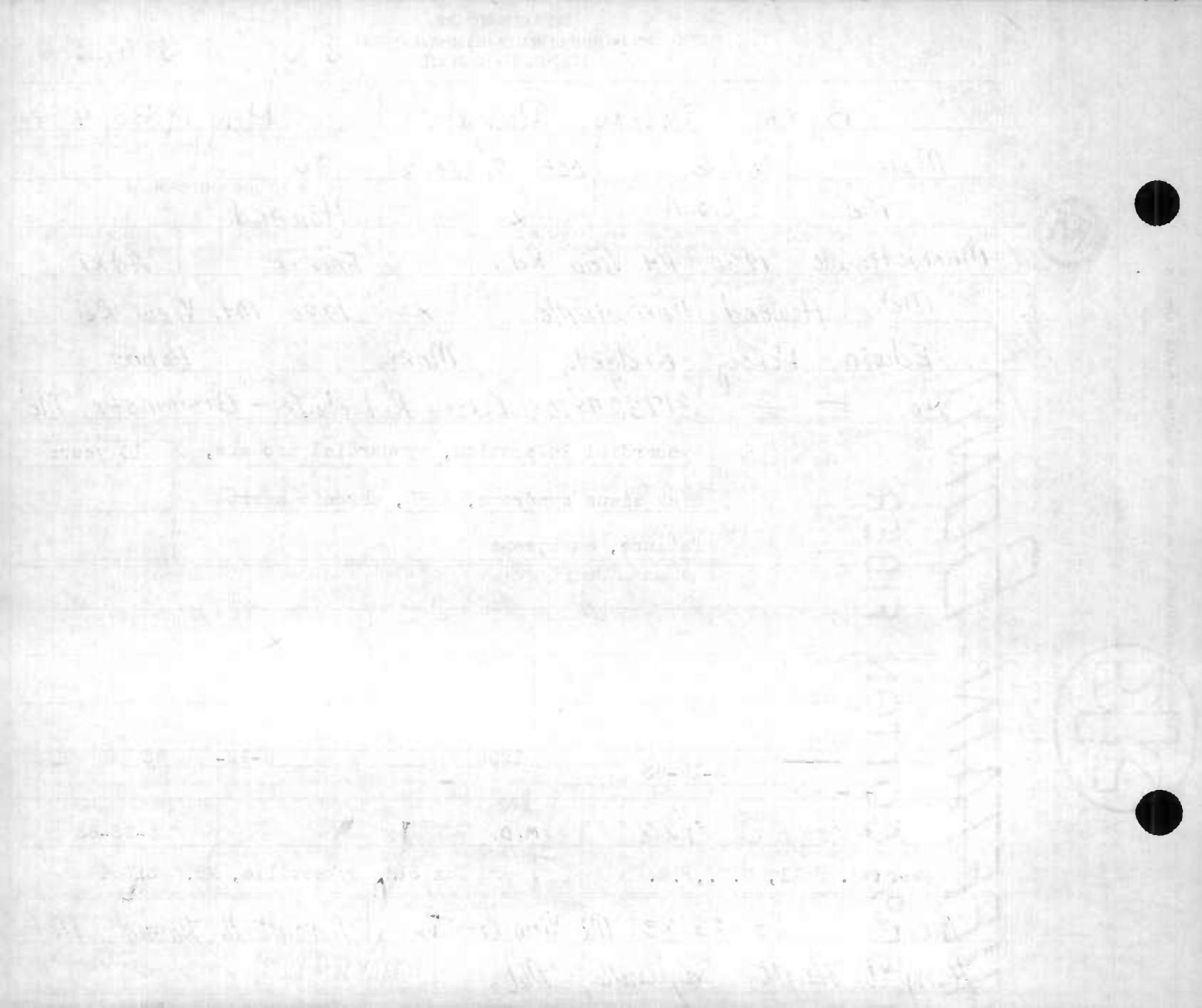
2400 notarized before me
DANIELLE BROWN
2400 notarized before me DANIELLE BROWN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, then please remove carbon papers. Pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be called in.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.	
1 - STATE REGISTRAR			2a. DATE OF DEATH									2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	MONTH	DAY	YEAR	DAY	YEAR	2b. HOUR		
Byron Dorsay Ridgely						OCT.	7	1902	May	19 83	4: PM		
3 SEX			4 RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)				
Male			White			MONTH	DAY	YEAR	80	IF UNDER 1 YEAR MONTHS DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9 BALTIMORE CITY OR COUNTY OF DEATH				
Md.			U.S.A.			MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	Howard			
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Marriottsville			1930 Mt. View Rd.									Farmer	AGRI.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS							
Md.	Howard	Marriottsville	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	1930 Mt. View Rd.			21104					
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
Edwin Dorsey Ridgely			MARY Hobbs										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No			217327810			Dorsey Ridgely Jr. - Westminster, Md.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)													
Myocardial infarction, myocardial ischemia, 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last { DO TO, OR AS A CONSEQUENCE OF (b) Sick sinus syndrome, ASHD, chronic heart failure, emphysema { DO TO, OR AS A CONSEQUENCE OF (c)													
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (was hospital) attended the deceased from 1958, 19, to 5-19- 19 83, that (I) (did not) last saw the deceased alive on 5-19-83, 19, and that in (my) () opinion death occurred on the date and hour and from the causes stated above, (I) () (did not) view the body after death.													
22b. SIGNATURE			22c. DEGREE			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED				
Howard E. Hall			M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			5-23-83				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			PO Box 318 Sykesville, Md. 21784							
Howard E. Hall, M.D., P.A.													
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN				
Burial			5-23-83			Mt. View Cemetery			Marriottsville, Howard, Md.				
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Harry W. Haight			Sykesville, Md.			MAY 24 1983			John J. Conroy				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

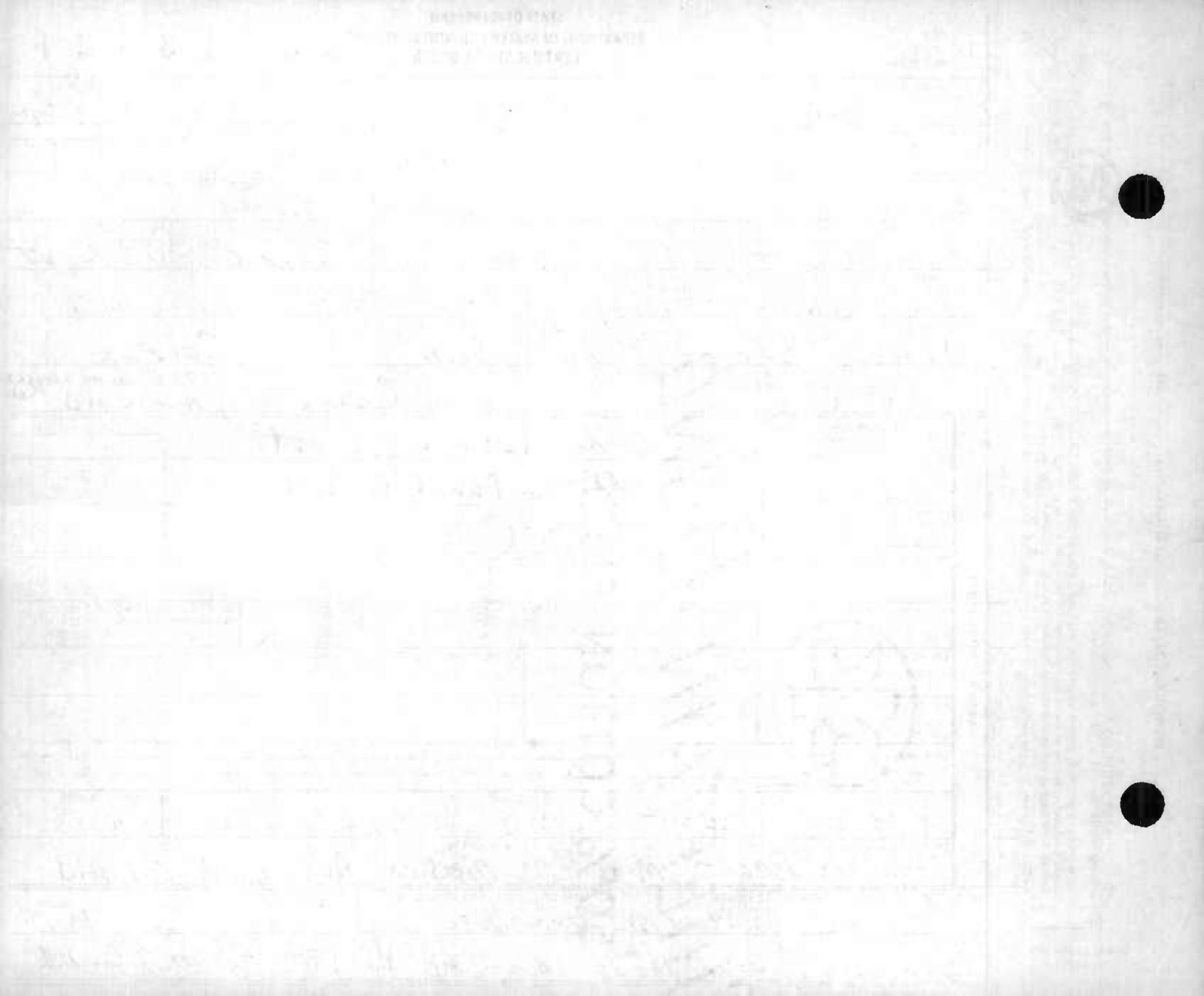
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified or one of the following forms must be completed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 3 6 2 1			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
OMA					Rodery	5 10 83						4:20 PM	
3. SEX		F	4. RACE		Cau	5. DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	
						Feb 27 1910						73	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		ARKANSAS	7b. CITIZEN OF WHAT COUNTRY?		USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 1 YEAR MONTHS DAYS	
10. CITY OR TOWN OF DEATH		Columbia, MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		Howard County General Hosp.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			CLERK			12b. KIND OF BUSINESS OR INDUSTRY MD. US GOVT	
13a. STATE		MD	13b. COUNTY		Howard	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			21045 Cradlerock Way	
14. FATHER'S NAME		JAMES	MIDDLE	LAST	21045	15. MOTHER'S MAIDEN NAME			ORA	16. ADDRESS			COOPER
FIRST		ERNEST		CLARK		FIRST			MIDDLE	10725 SCAGGSVILLE LAUREL MD			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		NO	16b. SOCIAL SECURITY NO.			17. INFORMANT			DAVID CLARK	ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4039 Cardio - Pulmonary Arrest													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b), (c) DUE TO, OR AS A CONSEQUENCE OF Chronic Renal Disease													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) none													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
							<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (the hospital) attended the deceased from 1979 to 1983, that (I) (was) lost saw the deceased alive on 5-10-1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death.													
22b. SIGNATURE Francis Bruno MD DEGREE													22c. DATE SIGNED 5-10-83
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
FRANCIS BRUNO M.D.		Medical Arts Build. Col, Md											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY/TOWN		COUNTY	STATE			
BURIAL		MAY 14, 1983		EMMANUEL Cem			Scaggsville		MD				
24. FUNERAL DIRECTOR NAME		ADDRESS					25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
DONALDSON FUNERAL HOME		LAUREL, MD					MAY 16 1983			John J. Canfield			

RECORDED DATE
10/10/2019
BY [redacted] - [redacted]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified on Item 21.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8313622				
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR MAY 14 1983									2b HOUR 12 ⁴⁵ P.M.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			6 AGE (IN YEARS LAST BIRTHDAY) 95 YRS				
Jessie Maude Roland												IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
3 SEX Female			4 RACE Cauc.			5 DATE OF BIRTH MONTH DAY YEAR 09 28 1887			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				
10 CITY OR TOWN OF DEATH Columbia, Md			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Ho Co Gen'l Hospital									12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				
13a STATE Maryland			13b COUNTY Howard			13c CITY OR TOWN Mt Airey			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			12c STREET ADDRESS 17140 Frederick Road 21771				
14 FATHER'S NAME FIRST MIDDLE LAST late James Boston			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST late Mary E Haycock													
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO 376 26 7020									17 INFORMANT ADDRESS Mrs Earl Drake 21771				
18 CAUSE OF DEATH (Enter only one cause per line for 10, 1b, and 1c.) PART I. DEATH WAS CAUSED BY. 4100 IMMEDIATE CAUSE (a) cardiogenic shock												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause 10, stating the underlying cause lost. (b) acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a N/A																
19a DATE OF OPERATION N/A			19b CONDITION FOR WHICH OPERATION WAS PERFORMED									20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> TO DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 1981 81 511 1985										
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK N/A			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 1981 81 511 1985			21f LOCATION STREET CITY OR TOWN COUNTY STATE										
22a I certify that (I) (this hospital) attended the deceased from 5/11 1983 to 5/11 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c DATE SIGNED 5/11/83				
22d PHYSICIAN'S NAME (TYPE OR PRINT) Win Flowers MD			22e ADDRESS Columbia, Md.									ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 14, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Grace Episcopal Cem			23d. LOCATION CITY OR TOWN Ellicott City			25a DATE REC'D. BY REGISTRAR MAY 17 1983			25b. REGISTRAR'S SIGNATURE John G. Canfield	
24 FUNERAL DIRECTOR NAME Harry H Witzke			ADDRESS 4112 Columbia Rd Ellicott City													

July 29, 1912 8837 PAY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

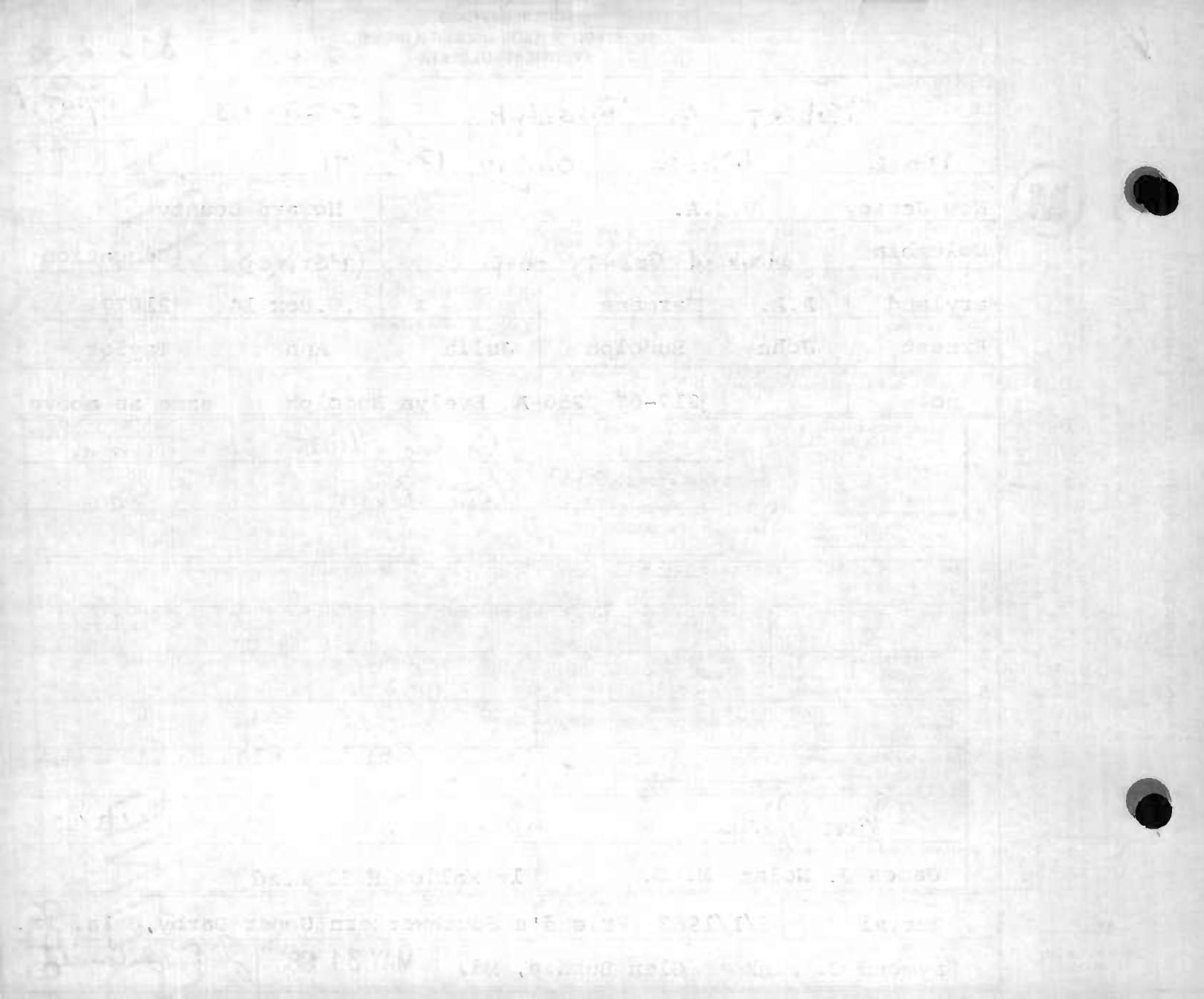
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, in the medical column, attach a report.

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8313623
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
<i>Robert E. Rudolph</i>						<i>5-28-83</i>				<i>7:08 P.M.</i>				
3. SEX			4 RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
<i>Male</i>			<i>White</i>	<i>02</i>	<i>10</i>	<i>12</i>	<i>71</i>							
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New Jersey</i>			8. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Howard County</i>			MD.		
10. CITY OR TOWN OF DEATH <i>Columbia</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Howard County Hosp.</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>(Retired)</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Education</i>					
13a. STATE <i>Maryland</i>		13b. COUNTY <i>A.A.</i>		13c. CITY OR TOWN <i>Harmans</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>P.O. Box 14 (21077)</i>						
14. FATHER'S NAME <i>Ernest</i> FIRST <i>John</i> MIDDLE <i>Rudolph</i> LAST			15. MOTHER'S MAIDEN NAME <i>Julia</i> FIRST <i>Ann</i> MIDDLE <i>Taylor</i> LAST											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. <i>217-07-8256</i>			17. INFORMANT <i>Evelyn Rudolph</i>			ADDRESS <i>same as above</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <i>4241</i>			IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Seconds</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) _____			(c) _____			DUE TO, OR AS A CONSEQUENCE OF <i>Arteric Stenosis</i>					
DUE TO, OR AS A CONSEQUENCE OF <i>Years</i>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (was hospital) attended the deceased from <i>Jan 19 1965</i> to <i>May 20 1983</i> , that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>James J. Nolan</i>			DEGREE <i>M.D.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>5/31/83</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>James J. Nolan M. D.</i>			22e. ADDRESS <i>1 = Mallow Hill Road</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>6/1/1983</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Friend's Southwestern Upper Darby, Dela. Pa.</i>			23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME <i>Raymond C. Fink</i>			ADDRESS <i>Glen Burnie, Md.</i>			25a. DATE REC'D. BY REGISTRAR <i>MAY 31 1983</i>			25b. REGISTRAR'S SIGNATURE <i>John L. Smith</i>					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE LEFT OF THE WORD "DECEASED". PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 3 AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 3 6 2 4		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED X			MONTH	DAY	YEAR	2b. HOUR		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.									
Male	White	3 24 27	86 yrs.						5-27-83					
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			Howard County					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Columbia			Howard Co. General Hospital			Self employed			Trucking					
13a. STATE Illinois			13b. COUNTY Kane			13c. CITY OR TOWN St. Charles			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 33W088 Toni Street 60174		
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			LAST			Freha		
Dietrich			Schultze			Bertha								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
Yes			WW 2			355-14-1361			Mrs. Bernita Schultze Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <i>Margarita Korell</i> TITLE (SPECIFY) M. Assistant MEDICAL EXAMINER														
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN					
Burial			5/31/83			Union Cemetery			St. Charles, Kane Illinois					
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR MAY 31 1983									25b. REGISTRAR'S SIGNATURE <i>John J. Walsh</i>		
Witzke, P.A.			ADDRESS 1630 Edmondson Ave Catonsville, Md. 21228											
DHMH - 17 (VR A15 ME (5)) 20M 4/82														

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52 53 54

55 56 57

28 29 30

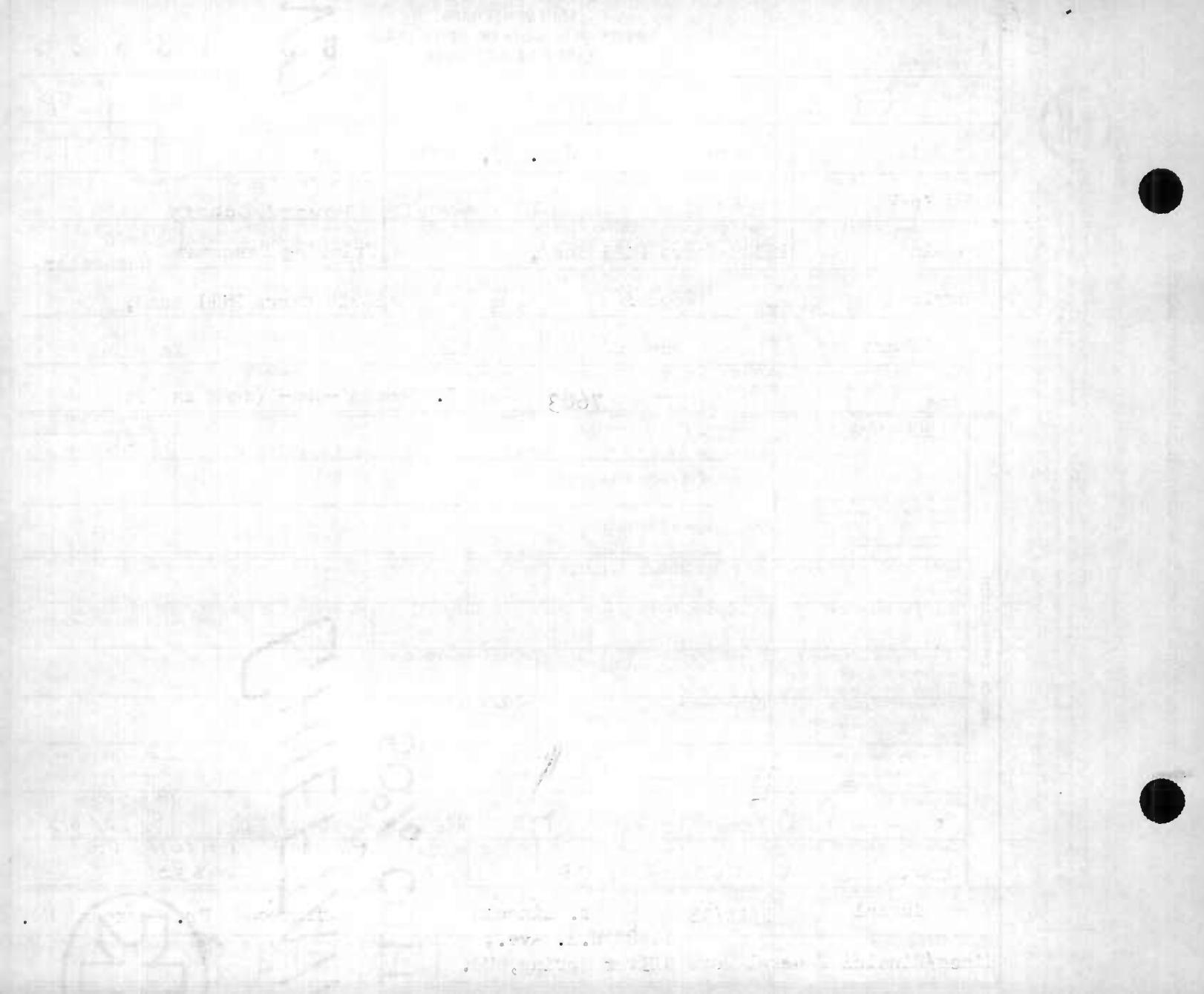
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be rehanded by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be held within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be informed and advised.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3	1 3 6 2 5		
										REG. NO.			
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			EMIL			TAMAGNI			MAY 13, 1983			12 th P M	
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Male			White		Jan. 3, 1903			80			MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS	
New York			USA						Howard County MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Woodbine			16328 Carrs Mill Road,			Printing Pressman			Budd & Detweiler				
13a. STATE Maryland			13b. COUNTY Howard		13c. CITY OR TOWN Woodbine			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 16328 Carrs Mill Road, 21797		
14. FATHER'S NAME Albert			15. MOTHER'S MAIDEN NAME Lena								LAST Bagninini		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT Jack E. Tamagni-son- (same as 13e)			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Yes			578 05 7683									9 MONTHS	
18. CAUSE OF DEATH (Enter only one cause per line for 1(a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2000 DIFFUSE HISTIOCYTIC LYMPHOMA													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b)													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from OCTOBER, 1982, to MAY 13, 1983, that (I) (we) last saw the deceased alive on MAY 11, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <input checked="" type="checkbox"/> (did not) view the body after death.													
22b. SIGNATURE Eugene P. Flannery			22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 5/13/83				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE P. FLANNERY, MD			22e. ADDRESS 16111 PRINCE PHILIP DR OLNEY, MD 20832										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/16/83			23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln			23d. LOCATION Brentwood			23e. COUNTIES Pr. Georges Md.	
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home Silver Spring, Md.			11800 N.H. Ave., Silver Spring, Md.			25a. DATE REC'D. BY REGISTRAR MAY 17 1983			25b. REGISTRAR'S SIGNATURE John J. Lavelle				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 3	1 3 6 2 6			
												REG. NO.				
I. DECEASED NAME Kymm <small>(TYPE OR PRINT)</small>												2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
FIRST Kymm MIDDLE A LAST Turner												05	29	83	128 a.m.	
3. SEX female		4. RACE black		5. DATE OF BIRTH MONTH 5 DAY 30 YEAR 62			6. AGE (IN YEARS LAST BIRTHDAY) MONTHS 26 YRS.			IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 128 MIN. 0				
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY Ohio		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Howard , MD.									
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student			12b. KIND OF BUSINESS OR INDUSTRY College									
13a. STATE Md.		13b. COUNTY Howard		13c. CITY OR TOWN Columbia			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 9326 Ourtime La., Md. 21045						
14. FATHER'S NAME Woodrow		MIDDLE W		LAST TURNER			15. MOTHER'S MAIDEN NAME Frances			LAST Turner						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 218-92-0984		16c. INFORMANT Frances Turner			16d. ADDRESS 9326 Ourtime La., Columbia, Md. 21045			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY:																
IMMEDIATE CAUSE (a) respiratory and cardiac arrest																
DUE TO, OR AS A CONSEQUENCE OF (b) hepatic failure																
DUE TO, OR AS A CONSEQUENCE OF (c) malignant teratoma, widely metastatic																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION NIP		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE						
22a. I certify that (I) (this hospital) attended the deceased from 2205 May 28 , 1983, to 128 May 29 , 1983, that (I) (we) last saw the deceased alive on May 29 , 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE Donna Myers		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 5-29-83									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donna Myers		22e. ADDRESS 3501 St Paul St, Balt, Md 21218														
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE 6/3/83		23c. NAME OF CEMETERY OR CREMATORIAL Highland View			23d. LOCATION CITY OR TOWN Warrenville			COUNTY	STATE					
24. FUNERAL DIRECTOR NAME Chas.A. Rice FSPA 1300 Eutaw Place		ADDRESS		25a. DATE REC'D. BY REGISTRAR JUN 3 1983			25b. REGISTRAR'S SIGNATURE John J. Carroll									

on site ~~drillings~~
samples
2003, 100 meters deep
A small amount of
spores in sediment sample 1000-20-15

different very healthy
soil microflora
and plants

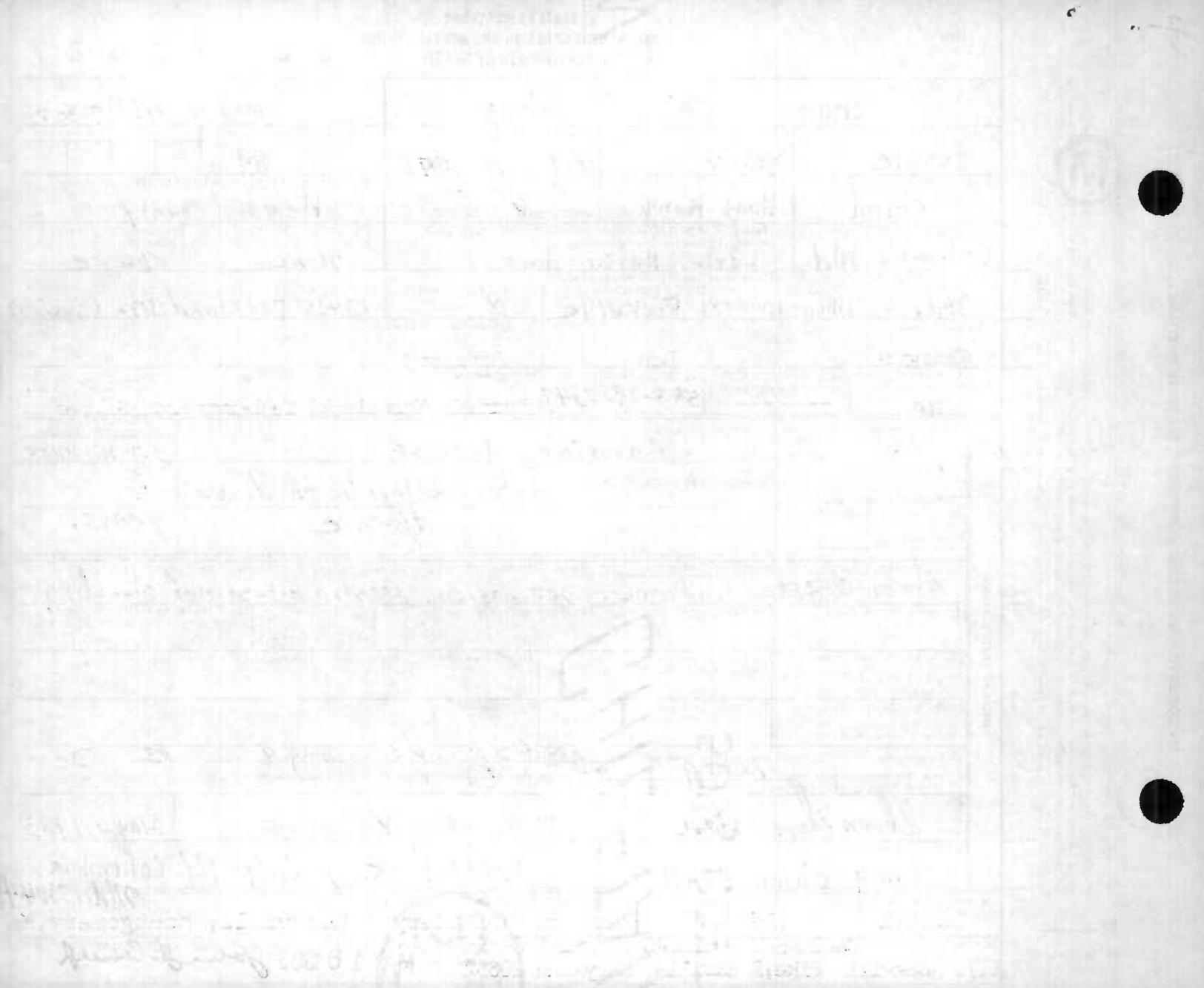
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 7 days of death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												83	13627		
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
chun			chi	Wong		May 9 1983					17:30 PM				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
female			yellow			Aug. 11 1893			89 yrs.			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
china			Hong Kong			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Howard county						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Columbia, Md.			Lorien Nursing Home			None			None						
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			
Md.			Montgomery			Rockville			13415 parkland Dr. (20853)						
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			16. SOCIAL SECURITY NO.			ADDRESS			
(Unknown)			Lau			(Unknown)			553-29-2347			Eng Spring, Md.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for 18, (b), and (c).) PART I. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) _____ Cardiac arrest DOUE TO, OR AS A CONSEQUENCE OF (b) _____ Arteriosclerotic cardiovascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ disease years.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minute			
no			-----												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Chronic Brain Syndrome. Depression. Gastro-intestinal bleeding.															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>APRIL 20, 1983</u> to <u>May 9, 1983</u> , to <u>May 9, 1983</u> , that (I) (we) lost saw the deceased alive on <u>May 9, 1983</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Chong cheon Han			DEGREE M.D..			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED May 9, 1983						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 10798 Hickory Ridge Rd. Columbia, Md. 21044												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/13/83			23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Cemetery			23d. LOCATION CITY OR TOWN Rockville; Montgomery; Md						
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Maryland 20852			ADDRESS			25a. DATE REC'D. BY REGISTRAR MAY 16 1983			REGISTRAR'S SIGNATURE John L. Cohen						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please return carbon copies, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, entombment, or removal.

IMPORTANT: If item 21 is marked as any injury, or other traumatic event, the medical examiner will be consulted about the cause of death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 REG. NO. 13628				
1. FOR STATE REGISTRAR			2. DATE OF DEATH MONTH YEAR							2b. HOUR				
(TYPE OR PRINT)			Ida Dobler			Worstell		5/1/83 May 1, 1983		3:45 PM				
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			M			
Female			Caucasian		Nov. 10, 1897			85			IF UNDER 1 YEAR			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8			YRS			MONTHS DAYS HOURS MIN.			
New York, USA			USA		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>									
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
ELLIOTT CITY			9202 Frederick Road							Housewife			N/A	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			
Florida			Broward		Ft. Lauderdale						2026 NE 29th St.			
14. FATHER'S NAME			FIRST MIDDLE		15. MOTHER'S MAIDEN NAME						Motelock Measlock			
Henry Christian			Dobler		Ida Marie									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS						
No			083-03-3310		Joan Worstell Carter, 9202 Frederick Rd.									
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY. 5900 IMMEDIATE CAUSE (a) renal failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause last (b) chronic nephrosclerosis. (c) chronic pyelonephritis.														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) N/A														
19a. DATE OF OPERATION N/A			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> N/A N/A			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>March 19, 82</u> , to <u>5/1, 1983</u> , that (I) (we) last saw the deceased alive on <u>3/19/83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.														
22b. SIGNATURE William Flowers. MP										22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William Flowers MD										22e. ADDRESS 10802 Hickory Ridge Rd Columbia MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 5/12/83			23c. NAME OF CEMETERY OR CREMATORIAL WESTVIEW MEM. PARK CATONSVILLE 21020 MD.			23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME JOSEPH LEE CAMPBELL 11590 INDIAN HILL DR			ADDRESS WEST FRIENDSHIP			25a. DATE REC'D. BY REGISTRAR MAY 2 1983			25b. REGISTRAR'S SIGNATURE Joseph Campbell					

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